MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5722

CERTIFICATE OF DEATH

05711

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 15 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Olney
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grace Middle: Ellen Last: Aber
4. DATE OF DEATH: Month 5 Day 20 Year 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/3/83
9. AGE (In years lost birthday): 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Indiana, USA
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Milton Quyle
14. MOTHER'S MAIDEN NAME: Susan Chowning
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Hospital Records. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary artery occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
420.1
DUE TO (b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): pneumonia, left lung; atrial fibrillation.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/5/61 19__, to 5/20/61 19__, that (I) (we) last saw the deceased alive on 5/20/61 19__, and that death occurred at 3:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: G. Meadors M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/20/61
22c. PHYSICIAN'S NAME (Type): G.F. Meadors, M.D.
22d. ADDRESS: Main Street, Damascus, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 22, 1961
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town, or county) (State): Washington, D.C.
24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE: MAY 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

pneumonia, left lung ; spinal cellulitis.

1 FOR STATE HEALTH DEPT.

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TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5723 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 06870

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: seven years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 192 Fleetwood Terrace

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 192 Fleetwood Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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3. NAME OF DECEASED (Type or print): First Charles Middle Edward Last Ackerman Jr.

4. DATE OF DEATH: Month May Day 31, Year 1961

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 8, 1889
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Budget & Fiscal officer
10b. KIND OF BUSINESS OR INDUSTRY: HG. U.S.A.F.
11. BIRTHPLACE (State or foreign country): Peekskill New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Edward Ackerman, Sr. New York
14. MOTHER'S MAIDEN NAME: Catherine Braceling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW2
16. SOCIAL SECURITY NO.: 215-26-3654
17. INFORMANT: Mr. Charles E. Ackerman, Address: 1913 Eries St. W. Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Total disabled six years
DUE TO (b) Pulmonary Emphysema
DUE TO (c) Cor pulmonale

434.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 6-1-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/5/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or country) (State): Arlington County, Virginia

23. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc. ADDRESS: 8434 Georgia Avenue Silver Spring, Maryland
Raymond A Ziska
24a. REC'D BY REGISTRAR DATE JUN 7 '61
24b. REGISTRAR'S SIGNATURE: Clifford L. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5724 **CERTIFICATE OF DEATH** 65712

Item 8 Film G288 6/1/61 iwk

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 21 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: Rt #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Peggy. Middle: N Last: Adams

4. DATE OF DEATH: Month: 5 Day: 17 Year: 1961

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/10/7/1922

9. AGE (In years last birthday): 39 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country):

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Hamilton

14. MOTHER'S MAIDEN NAME: Bertha Mosley.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Leroy Adams (Husband) Address: Same.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Exsanguination — INTERVAL BETWEEN ONSET AND DEATH
151X
DUE TO (b) Perforated Gastric Ulcer — 2 mo
DUE TO (c) Carcinoma, stomach — 9 mo

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-16, 1961, to 5-17, 1961, that (I) (we) last saw the deceased alive on 5-17 1961, and that death occured at 6 9 M, from the causes and on the date stated above.

22a. SIGNATURE: J. Roscoe Creer M.D. M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): J. Roscoe Creer

22d. ADDRESS: 1800 Eye St. N.W. Wash. 6 D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): SHIPPED

23b. DATE THEREOF: 5/22/61

23c. NAME OF CEMETERY OR CREMATORY: THOMPSON & CARPENTER FUN. HOME, SPARTANSBURG, S. C.

23d. LOCATION (City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden ADDRESS: ROCKVILLE, MD.

25a. REC'D BY REGISTRAR DATE MAY 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3725

CERTIFICATE OF DEATH

05713

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7113 Poplar Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

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3. NAME OF DECEASED (Type or print): First Charles, Middle A., Last Alexander

4. DATE OF DEATH: Month May, Day 16, Year 1961

5. SEX: Male
6. COLOR OR RACE: Cauc
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 3-1-78
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Paper Products
11. BIRTHPLACE (County & State, or foreign country): Hungary
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Sigmond Alexander
14. MOTHER'S MAIDEN NAME: Helen (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not or unkown): No
(If yes give war or dates of service): -
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Son-in-Law Address: Mr Harry Gettleman 7113 Poplar Ave. Tk. Pk

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.
6000
DUE TO (b): Pyelonephritis — 5+ yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus; Paget's Disease of Bone
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/16, 1961, to May 16, 1961, that (I) (we) last saw the deceased alive on May 16 1961, and that death occured at 8:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Norman H. Rubenstein M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: 5/17/61
22c. PHYSICIAN'S NAME (Type): NORMAN H. RUBENSTEIN
22d. ADDRESS: 6480 N.H. Ave. Takoma Park, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 19, 1961
23c. NAME OF CEMETERY OR CREMATORY: Rabbi Isaac Elchonan Cem.
23d. LOCATION (City, town or county) (State): Everett, Mass.

24. FUNERAL DIRECTOR'S SIGNATURE: Goldberg Funeral Home
ADDRESS: 4217 Geo. St. NW
25a. REC'D BY REGISTRAR DATE MAY 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5726 45714

075

1. PLACE OF DEATH
e. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Erie
d. STREET ADDRESS: 533 Shenley Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75X-3

3. NAME OF DECEASED (Type or print): First: Mildred; Middle: Marie; Last: Anderson
4. DATE OF DEATH: Month: 5; Day: 18; Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-11-05
9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Erie, Penna
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Frank Anderson
14. MOTHER'S MAIDEN NAME: Anna Butzer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hosp Records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
157X
DUE TO (b): Carcinoma of pancreas (Head) — 1 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 13, 1961, to May 18, 1961, that (I) ~~(we)~~ last saw the deceased alive on May 18 1961, and that death occured at 8:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Raymond O. West M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): RAYMOND O. WEST.
22d. ADDRESS: 7600 Carroll Ave. Takoma Park. Md.

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23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 24, 1961
23c. NAME OF CEMETERY OR CREMATORY: Home Cemetery
23d. LOCATION (City, town or county) (State): Youngstown, Ohio.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St NW DC
25a. REC'D BY REGISTRAR DATE MAY 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO BURIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completely filled in by the attending physician within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5727 05715

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1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Dawsonville

c. LENGTH OF STAY IN 1b: 9 yr

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Md R-121 - Boyds

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE: Md b. COUNTY: Monty

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dawsonville

d. STREET ADDRESS: Md R-121 Boyds

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Harvey Middle: Appleman Last:

4. DATE OF DEATH: Month: May Day: 26 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: 9-28-'71

9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired School Board Employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Isaac Appleman

14. MOTHER'S MAIDEN NAME: Rose Daniel -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Jane Peters Address: 133 Aldrich Rd Columbus Ohio

MEDICAL CERTIFICATION

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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage + laceration

DUE TO (b) bullet wound in skull

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound in skull

20c. TIME OF INJURY: Hour 8:45 a.m. Month, Day, Year 5-26 1961

20d. INJURY OCCURRED: While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

20f. (City or town): Dawsonville (County): Monty (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. Broschart

CHIEF MEDICAL EXAMINER [ ]

ASSISTANT MEDICAL EXAMINER [ ]

DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county):

DATE SIGNED: 5-26-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 29-61

22c. NAME OF CEMETERY OR CREMATORY: River Forest -

22d. LOCATION (City, town, or country): South Bend (State): Indiana

23. FUNERAL DIRECTOR: William C. Helton ADDRESS: Barnesville, Md

24a. REC'D BY REGISTRAR DATE MAY 31 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5728 — 05717

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San & Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Monr
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 9430 R. I. Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1669-2

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Clifton — Last: Ashby

4. DATE OF DEATH: Month: 5 — Day: 10 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 6/7/86

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Govt retired

10b. KIND OF BUSINESS OR INDUSTRY: CARETAKER

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: America

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): — None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hosp. record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/10, 1961, to 5/10, 1961, that (I) (we) last saw the deceased alive on 5/10, 1961, and that death occured at 7:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Howard T. Morse M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): HOWARD T. MORSE

22d. ADDRESS: 7030 Carroll Ave, Takoma Park md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/13/61

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

23d. LOCATION (City, town or county) (State): Suitland md.

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Shanklin & Son Inc. — ADDRESS: Riverdale Md. 5801 E. Kenilworth Ave.

25a. REC'D BY REGISTRAR — DATE: MAY 12 '61

25b. REGISTRAR'S SIGNATURE: William S. Thomas

TO MEDICAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5729 Items 18-21, Film G-287 5/15/61.cac. 05718

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington San & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7335 Carroll Ave
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Robin Middle: Louise Last: Atchley
4. DATE OF DEATH: Month: May Day: 1 Year: 1961 19

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 2/14/60
9. AGE (In years last birthday): 1 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Euel Atchey
14. MOTHER'S MAIDEN NAME: Esther Nixon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Euel Atchey Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Miltown poisoning — INTERVAL BETWEEN ONSET AND DEATH: 1½ days
871.0
DUE TO
(b) Blood contained 20 mg.% Meprobamate
DUE TO
(c) Liver contained 18mg. % Meprobamate.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Took Miltown tabs. at home.
20c. TIME OF INJURY: Hour 8-9 a.m. p.m. Month, Day, Year 4-29-1961
20d. INJURY OCCURRED: While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Takoma Park, Montgomery, Md.

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county):
DATE SIGNED: 5/2/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 3, 1961
22c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery
22d. LOCATION (City, town, or country): Prince George County (State): Md.

23. FUNERAL DIRECTOR: J. Arthur Walters
ADDRESS: 254 Carroll St NW. D.C.
24a. REC'D BY REGISTRAR DATE MAY 3 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5730 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05719

Item 14 Film 0288 6/12/61 mb

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: DOA.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montg Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: P. G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
d. STREET ADDRESS: 7201 Rivendale Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Helena Middle Wellinia Last Baier
4. DATE OF DEATH: Month May Day 30 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-5-1881
9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Geo. Baier
14. MOTHER'S MAIDEN NAME: Elizabeth Dilger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give year or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Florence Gute (niece) Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial Infarction
DUE TO (b): Coronary Thrombosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 5-31-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6/3/61
22c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
22d. LOCATION (City, town, or country) (State): Alexandria Virginia

23. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville, Md.
24a. REC'D BY REGISTRAR DATE JUN 2 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5731 05720

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Alexandria
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 4535 Taney Ave. - Apt. 203
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

63X-3

3. NAME OF DECEASED (Type or print): First: Anthony — Middle: Edward — Last: BAKER
4. DATE OF DEATH: Month: May — Day: 15 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 14, 1961
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 16 — Min.: 23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - - - - -
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - -
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George Edwin BAKER
14. MOTHER'S MAIDEN NAME: Lea Marie FERRARI
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (F) George E. Baker, same as #2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 16 hrs. 23 mins.
776X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from May 14, 1961 to May 15, 1961, that I (we) last saw the deceased alive on May 15, 1961, and that death occured at 7:30AM, from the causes and on the date stated above.

22a. SIGNATURE: Lawrence G. Thorne M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 5-15-61
22c. PHYSICIAN'S NAME (Type): Lawrence G. THORNE, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment
23b. DATE THEREOF: 5-16-61
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d. LOCATION (City, town or county): Norfolk — (State): Virginia
24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey J.B. — ADDRESS: R. A. Pumphrey Funeral Home, Bethesda, Md.
25a. REC'D BY REGISTRAR DATE: MAY 18 '61
25b. REGISTRAR'S SIGNATURE: Anthony S. Krauss

TO [redacted]AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be [redacted] within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2051202 XVI

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5732 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05721

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2 hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Meth. Church - E. W. Hy. & Fort Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 2620 Coulton Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas Middle Harvey Last Baker
4. DATE OF DEATH: Month May Day 26 Year 1961
5. SEX: Male
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-11-1907
9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister
10b. KIND OF BUSINESS OR INDUSTRY: Meth.
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Harvey Baker
14. MOTHER'S MAIDEN NAME: Bessie Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 220-34-2722 Not located
17. INFORMANT: Eliz. Baker (wife) Address: Silver Sp

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of previous coronary disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Boschard M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-26-61
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 29, 1961
22c. NAME OF CEMETERY OR CREMATORY: Prospect Hill Park Cemetery
22d. LOCATION (City, town, or country): Towson, Maryland (State)

23. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc. ADDRESS: Silver Spring, Md.
Raymond A. Zeska
24a. REC'D BY REGISTRAR DATE JUN 1 '61
24b. REGISTRAR'S SIGNATURE: Anthony S. Krasa

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death; if autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5733

CERTIFICATE OF DEATH

65722

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fanwood
d. STREET ADDRESS: 167 Belvidere Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

67X-3

3. NAME OF DECEASED (Type or print): First: Katherine Middle: Beatrice Last: Bateman

4. DATE OF DEATH: Month: May Day: 14 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 2, 1918
9. AGE (In years lost birthday): 42 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Canada
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harold W. Ireland
14. MOTHER'S MAIDEN NAME: Olive B. Hambley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 146-32-2351
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
DUE TO
(b) Hypertensive Cardiovascular Disease — 8 years
DUE TO
(c)

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 11, 1961 to May 14, 1961, that (I) (we) last saw the deceased alive on May 14, 1961, and that death occurred at 4:12 PM from the causes and on the date stated above.

22a. SIGNATURE: Thomas E. Gaffney M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5/15/61
22c. PHYSICIAN'S NAME (Type): THOMAS E. GAFFNEY, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/16/61
23c. NAME OF CEMETERY OR CREMATORY: —
23d. LOCATION (City, town, or county) (State): Toronto, Canada

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. ADDRESS: 3072-M St NW Wash. DC
25a. REC'D BY REGISTRAR DATE: MAY 17 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 must be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5734

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15723

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 4 yr
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 3515 Plyers Mill Ct.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mntg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 42 Kensington
d. STREET ADDRESS: 3515 Plyers Mill Ct
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry; Middle: Bauer; Last:
4. DATE OF DEATH: Month: May; Day: 22; Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-7-1913
9. AGE (In years last birthday): 47 Yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10b. KIND OF BUSINESS OR INDUSTRY: OWN
11. BIRTHPLACE (State or foreign country): N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Carlo Bauer — Germany
14. MOTHER'S MAIDEN NAME: Victoria Tatarsik — Poland
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 225-05-0294
17. INFORMANT: Vivian Bauer (wife) — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Fixed dead in bed
4201
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of previous Coronary disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broshart M.D.
EXAMINER'S NAME (Type): FRANK J. Broshart
Address (Street, city, town, or county):
DATE SIGNED: 5-22-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: May 25, 1961
22c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY
22d. LOCATION (City, town, or country) (State): Montgomery County, Maryland

23. FUNERAL DIRECTOR: Raymond A. Roska — Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue, Silver Spring, Md.
24a. REC'D BY REGISTRAR: DATE MAY 29 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death and by you if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS. A15ME
5M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5735

CERTIFICATE OF DEATH

Item 2 Film 0287 5/22/61 mh

05724

1. PLACE OF DEATH a. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL — SILVER SPRING
c. LENGTH OF STAY IN 1b: 5 YRS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SEYMOUR NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville 13
d. STREET ADDRESS: 14700 Crossway Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First TERESA Middle V Last BAZZURO
4. DATE OF DEATH: Month MAY Day 13 Year 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-21-1881
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): WASH., D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: BERNARD OSTMANN
14. MOTHER'S MAIDEN NAME: MARY LOCHBOEHLER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: MARY REED Address: 14700 CROSSWAY RD. ROCKVILLE 13, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC CARDIAC DECOMPENSATION — INTERVAL BETWEEN ONSET AND DEATH: YEARS

DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY 10 1961, to MAY 13, 1961, that (I) (we) last saw the deceased alive on MAY 12, 1961, and that death occurred at 5 A M, from the causes and on the date stated above.

22a. SIGNATURE: Gene U. Cohen M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: MAY 13, 1961
22c. PHYSICIAN'S NAME (Type): GENE U. COHEN, M.D.
22d. ADDRESS: 931 PERSHING DR. SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/16/61
23c. NAME OF CEMETERY OR CREMATORY: St. Marys
23d. LOCATION (City, town, or county) (State): Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Frank Geiers Sons Co. ADDRESS: 3605-14 St NW Wash. D.C.
25a. REC'D BY REGISTRAR DATE: MAY 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

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FOR STATE HEALTH DEPT.

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TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death and a copy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5736 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05725

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 14 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 420 Deerfield Ave

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 420 Deerfield Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leah — Middle: — Last: Berman

4. DATE OF DEATH: Month: May — Day: 3 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-15-96
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Russian
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HILLEL Kramm
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Goldie Stoller — Address: Ithum 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of previous coronary disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 5-3-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/5/61
22c. NAME OF CEMETERY OR CREMATORY: ~~NATL MEM.~~ Tom
22d. LOCATION (City, town, or country) (State): FALLS CHURCH VA

23. FUNERAL DIRECTOR: Goldberg Funeral Home
ADDRESS: 4217-9 Ga Ave
24a. REC'D BY REGISTRAR: DATE MAY 5 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5737 05726

1. PLACE OF DEATH
a. COUNTY Montgomery ~~Maryland~~ MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 24 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE California
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) San Bernardino
d. STREET ADDRESS 1126 W. Marshall Blvd.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Eleanor Middle: Marie Last: Binney

4. DATE OF DEATH Month: May Day: 11 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 17 1897
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Theodore Schoefer
14. MOTHER'S MAIDEN NAME: Anna (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Frank H. Binney - husband Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diabetic Acidosis — INTERVAL BETWEEN ONSET AND DEATH: 6 days.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Atelectasis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 5-5 1961, to 5-11 1961, that (I) ~~(we)~~ last saw the deceased alive on 5-11 1961, and that death occurred at 1:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE James W Egan M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED May 11, 1961
22c. PHYSICIAN'S NAME (Type) JAMES W. EGAN
22d. ADDRESS 7720 Wisconsin Ave, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit
23b. DATE THEREOF 5-11-61
23c. NAME OF CEMETERY OR CREMATORY Mountain View Cem.
23d. LOCATION (City, town, or county) (State) San Bernardino, Calif.

24. FUNERAL DIRECTOR'S SIGNATURA ROBERT A. PUMPHREY ADDRESS Bethesda, Md.
Robert A. Pumphrey - LN
25a. REC'D BY REGISTRAR DATE MAY 15 '61
25b. REGISTRAR'S SIGNATURE Arthur L. Hund

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5738 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 65727

Items 16 & 21, Film G-287 5/15/61. cac.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 9904 Sutherland Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9904 Sutherland Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lester; Middle: S.; Last: Birely Jr.
4. DATE OF DEATH: Month: May; Day: 8; Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 27 1927
9. AGE (In years last birthday): 33 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): electronic eng.
10b. KIND OF BUSINESS OR INDUSTRY: Vitro Corp.
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Lester S. Birely
14. MOTHER'S MAIDEN NAME: Elinor Beard
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 212-24-7359
17. INFORMANT: Lester S. Birely Address: Thurmont, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Combined barbiturate and alcohol poisoning.
971.8
DUE TO (b): Blood contained 1.6 mg. % barbiturate and 0.29 % alcohol.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 5-8-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-10-61
22c. NAME OF CEMETERY OR CREMATORY: Blue Ridge Cemetery
22d. LOCATION (City, town, or country) (State): Thurmont, Maryland

23. FUNERAL DIRECTOR: Raymond E. Creager
ADDRESS: Thurmont, Md.
24a. REC'D BY REGISTRAR DATE MAY 11 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5739 **CERTIFICATE OF DEATH** 65728

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Florida
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tallahassee
d. STREET ADDRESS: RR 4, Box 226
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

48X-3

3. NAME OF DECEASED (Type or print): First: William — Middle: Douglas — Last: BLOWERS
4. DATE OF DEATH: Month: May — Day: 16 — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-23-36
9. AGE (In years last birthday): 25 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William BLOWERS
14. MOTHER'S MAIDEN NAME: Margaret BAKER

I

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give year or dates of service): 1953 to DOD
16. SOCIAL SECURITY NO.: 219-32-5885
17. INFORMANT: (W) Mrs. Barbara K. Blowers, same as item #2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Diffuse cerebritis and brain abscess — INTERVAL BETWEEN ONSET AND DEATH: 3 wks
DUE TO (b) unknown cause
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

343X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from 6 May 19 61 to 16 May 19 61, that (☒ (we) last saw the deceased alive on 16 May 19 61, and that death occured at 12:01PM, from the causes and on the date stated above.

22a. SIGNATURE: J H Miller — M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-16-61
22c. PHYSICIAN'S NAME (Type): J. H. MILLER LT MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-19-61
23c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.
23d. LOCATION (City, town or county) (State): Baltimore Md.

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. Inc — ADDRESS: W.W.Chambers Co.,1400 Chapin St.,NW, WashDC

25a. REC'D BY REGISTRAR: MAY 18 '61 — DATE
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Montgomery Florida

Bethesda (Naval) 10 days Tallahassee

U. S. Naval Hospital NR 4, Box 220 x

William Douglas BLOWERS May 16 61

Male Caucasian x 3-23-36 25

Officer U. S. Navy Maryland USA

William BLOWERS Margaret BAKER

Yes 1953 to NOD 219-32-5865 (W) Mrs. Barbara K. Blowers, same as item 2

x

x

6 May 61 15 May 61 x

16 May 61 12:01PM

x 3-10-61

3. R. MILLER LT MC, USN U. S. Naval Hospital, Bethesda, Md.

Burial 3-10-61 Baltimore National Cem. Baltimore Md.

R.R.Chambers Co., 1400 Chapin St., N.W., WASHDC

1

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5740

CERTIFICATE OF DEATH

Reg. Dist. No. 5729

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boyds
c. LENGTH OF STAY IN 1b: 4 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Buck Lodge Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mt. Airy
d. STREET ADDRESS: RFD # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: H. — Last: Bolton

4. DATE OF DEATH: Month: May — Day: 9 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Sept. 11, 1882

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Montgomery Co., Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Bolton

14. MOTHER'S MAIDEN NAME: Sarah Anne Bolton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-16-7979

INFORMANT: Raymond E. Justice — Address: Mt. Airy, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
331X
DUE TO (b): Cerebral Arteriosclerosis — 1 year
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 24 Dec, 1960, to 9 May, 1961, that I last saw the deceased alive on 9 May, 1961, and that death occurred at 3:20 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: John M. Smith M.D. — ADDRESS (Street, city or town, state): Barnesville, Md — DATE SIGNED: 9 May 61

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 12, 1961

22c. NAME OF CEMETERY OR CREMATORY: Rockville

22d. LOCATION (City, town, or county) (State): Rockville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Olin L. Molesworth — ADDRESS: Damascus, Md.

24a. REC'D BY REGISTRAR — DATE: MAY 15 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5741

CERTIFICATE OF DEATH

65730

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 29 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4117 Beck Street, S. E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Beulah — Middle: Marie — Last: BOSWORTH

4. DATE OF DEATH: Month: May — Day: 19 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-26-81

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Govt.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Notley HOWELL

14. MOTHER'S MAIDEN NAME: Mabel (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: None

17. INFORMANT: (H) Dudley C. Bosworth, same as #2 above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma, n. e. c. primary unknown — INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1997

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ☒ (this hospital) attended the deceased from April 20 1961 to May 19 1961, that (I) (we) last saw the deceased alive on May 19 1961, and that death occured at 2:40AM, from the causes and on the date stated above.

22a. SIGNATURE: James M. Young M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5-19-51

22c. PHYSICIAN'S NAME (Type): James M. YOUNG, LT, MC, USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/22/61

23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

23d. LOCATION (City, town or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: Lee Funeral Home, 4th & Mass. Aves., NW, WashDC

25a. REC'D BY REGISTRAR DATE: MAY 23 '61

25b. REGISTRAR'S SIGNATURE: Lionel S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Montgomery District of Columbia

Bethesda (Naval) 29 days Washington

U. S. Naval Hospital 4117 Rock Street, S. E. x

Beulah Marie DOSWORTH May 19 61

Female Caucasian 8-20-61 79

Clerk U. S. Govt. Maryland USA

Notley ROWELL Mabel (Unknown)

Yes WWI None (H) Dunlay C. Bosworth, same as #2 above

x

x May 19 61 April 20 61 May 19 61 x

2:40AM

x 3-19-31

James M. YOUNG, Lt, MC, USN U. S. Naval Hospital, Bethesda, Md.

Burial Glenwood Cemetery Washington, D. C.

Lee Funeral Home, 4th & Mass. Ave., NW, Washdc

126

FOR STATE HEALTH DEPT. M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5742

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65731

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 35 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Edson Lane

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: Edson Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Graff — Last: Bowie

4. DATE OF DEATH: Month: May — Day: 23 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-7-1893
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John D. Graff
14. MOTHER'S MAIDEN NAME: Elizabeth Ray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mary Ellen Brewer — Address: Newman-Wolfe Co. Rockville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): History of previous heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 5-23-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/26/61
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or country) (State): Washington, D. C.

23. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE MAY 25 '61
24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5743 **CERTIFICATE OF DEATH** 05732

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 831 ~~813~~ Gist Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS; Middle MARSHALL; Last BRADY

4. DATE OF DEATH: Month May; Day 1; Year 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2-2-92

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: US.

13. FATHER'S NAME: George A. Brady

14. MOTHER'S MAIDEN NAME: Sarah Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 579-12-8579

17. INFORMANT: Daughter, Mary Anne Brady Sinclair — Address: 813 Gist Ave, Silver Spring, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Infarction, myocardium
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.0

INTERVAL BETWEEN ONSET AND DEATH: 15 mos / years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ~~I~~ XX (this hospital) attended the deceased from 28 April, 1961, to 1 May, 1961, that ~~I~~ (we) last saw ~~the~~ deceased alive on 1 May 1961, and that death occured at 6:04 PM from the causes and on the date stated above.

22a. SIGNATURE: Russell Miller, Jr. MD — M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 1 May 1961

22c. PHYSICIAN'S NAME (Type): RUSSELL MILLER, JR. LT MC USN

22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-4-61

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Norman J. Graber for — **ADDRESS**: W.E. PUMPHREY FUNERAL HOME, SILVER SPRING MD

25a. REC'D BY REGISTRAR — DATE: MAY 4 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

5744

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05733

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3218 E. Thornapple Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 3218 E. Thornapple Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

52

3. NAME OF DECEASED (Type or print): First: Harry — Middle: A — Last: Bright

4. DATE OF DEATH: Month: May — Day: 22 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 5, 1891

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months: 3, Days: 17 — IF UNDER 24 HRS.: Hours: , Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chemist

10b. KIND OF BUSINESS OR INDUSTRY: Chemistry

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Layman Bright

14. MOTHER'S MAIDEN NAME: Emma Madora

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Lynne A. Bright-wife-same 2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 15-30 min
DUE TO (b): Congestive heart failure — 9 months
DUE TO (c): Valvular heart disease — congenital

754.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec, 1960 to 22 May, 1961, that I last saw the deceased alive on 15 May, 1961, and that death occurred at 11:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Herbert Martyn Jr M.D. — ADDRESS (Street, city or town, state): 5029 BETHESDA AVE — DATE SIGNED: 22 May 61

PHYSICIAN'S NAME (Type): HERBERT MARTYN JR Bethesda Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/24/61

22c. NAME OF CEMETERY OR CREMATORY: Charles Evans Cem.

22d. LOCATION (City, town, or county) (State): Reading, Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: MAY 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

W. ill log
Twin A 5745

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05734

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: C/o Laytonsville P.O.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wilbur (Illegible) Middle: Eugene (Illegible) Last: BRIGHT, Jr.

4. DATE OF DEATH Month: MAY Day: 21 Year: 1961

5. SEX: MALE
6. COLOR OR RACE: Colored
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 5/21/61
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: 1 Min.: 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILBUR EUGENE BRIGHT
14. MOTHER'S MAIDEN NAME: SHIRLEY — LYLES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis
DUE TO
(b): Immaturity
DUE TO
(c): Twin Pregnancy

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 762.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: a. m. p. m. Month: Day: Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/21, 1961, to 5/21, 1961, that I last saw the deceased alive on 5/21, 1961, and that death occurred at 9:20 p.m., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Francis Lowen M.D.

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/24/61
22c. NAME OF CEMETERY OR CREMATORY: Brooke Grove Cem.
22d. LOCATION (City, town, or county) (State): Laytonsville, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Browden
ADDRESS: Rockville, Md
24a. REC'D BY REGISTRAR DATE: MAY 29 61
24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Twin 5746 wt 1 lb 9 oz

CERTIFICATE OF DEATH

Reg. Dist. No. 05735

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: C/o Laytonsville P.O.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Wilma Middle Marria Last Smith Bright
4. DATE OF DEATH: Month May Day 21 Year 1961

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 21, 1961
9. AGE (In years last birthday): — yrs.
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours 10 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wilbur Eugene Bright
14. MOTHER'S MAIDEN NAME: Shirley Lyles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mother Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) atelectasis
762.5
DUE TO
(b) immaturity
DUE TO
(c) Twin Pregnancy

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/21, 1961, to 5/21, 1961, that I last saw the deceased alive on 5/21, 1961, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Francis Lowrey M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/24/61
22c. NAME OF CEMETERY OR CREMATORY: Brooke Grove Cem.
22d. LOCATION (City, town, or county) (State): Laytonsville, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden
ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE: MAY 29 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

227183XVO

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5747 65736

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington San. & Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District of Columbia
d. STREET ADDRESS: 1400 Holly Street N/W
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Susie; Middle: B. (~~Mrs.~~); Last: Broadhurst

4. DATE OF DEATH: Month: 5; Day: 10; Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: 1-25-98
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months: 3; Days: 13
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: American

13. FATHER'S NAME: John Lindsay, Va.
14. MOTHER'S MAIDEN NAME: Susie Boswell - Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Posterior Myocardial Infarction — Interval between onset and death: 2 1/2 days
DUE TO (b) Coronary occlusion — 2 1/2 days
DUE TO (c) Arteriosclerotic Heart Disease — 5 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 1957 to May 10, 1961, that (I) (~~we~~) last saw the deceased alive on May 10, 1961, and that death occured at 2:20 p.m., from the causes and on the date stated above.

22a. SIGNATURE: Russell B. Arnold M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Russell B. Arnold M.D.
22d. ADDRESS: 8801 Colesville Road, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/13/61
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince George's Co. Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska
ADDRESS: Warner E. Pumphrey, Inc. 8434 Georgia Ave. Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE: MAY 16 '61
25b. REGISTRAR'S SIGNATURE: Carlton S. Keyes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5748

CERTIFICATE OF DEATH

05737

1 (M) (I)

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Barnesville
c. LENGTH OF STAY IN 1b: 71 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Barnesville
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Hatton — Middle: Darby — Last: Brown

4. DATE OF DEATH: Month: May — Day: 26 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Jan.2-1890

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer----Owner--Active

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Clifton Brown

14. MOTHER'S MAIDEN NAME: Mary Darby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give wars or dates of service)

16. SOCIAL SECURITY NO.: 270-07-7642

17. INFORMANT: Richard Brown, Barnesville, Md — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min.
420.1
DUE TO (b): Coronary arteriosclerosis — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 22 April, 1961, to 26 May, 1961, that (I) ~~(we)~~ last saw the deceased alive on 23 May 1961, and that death occured at 4:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Gordon M Smith — M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 27 May 61

22c. PHYSICIAN'S NAME (Type): Gordon M.Smith

22d. ADDRESS: Barnesville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 29-1961

23c. NAME OF CEMETERY OR CREMATORY: Monocacy

23d. LOCATION (City, town or county) (State): Beallsville, Md

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: William B. Hilton, Barnesville Md

25a. REC'D BY REGISTRAR: MAY 31 61 — DATE

25b. REGISTRAR'S SIGNATURE: Clifford L. Holland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Montgomery Maryland Montgomery

Burnesville 71 yrs Burnesville

Hatton Darby Brown May 26 61

Male White Jan.2-1890 71

Farmer---Owner--Active Maryland U.S.

Clifton Brown Mary Darby

NO 270-07-7042 Richard Brown,Burnesville,Md

Gordon H. Smith Burnesville,Md

Burial May 29-1961 Monocacy Beallsville,Md

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5749

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05738

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 8009 Maple Ridge Rd

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mnty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 8009 Maple Ridge Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47

3. NAME OF DECEASED (Type or print): First: William — Middle: Harry — Last: Buehm

4. DATE OF DEATH: Month: May — Day: 29 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-3-'42
9. AGE (In years last birthday): 18 Yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Graef W. Buehm
14. MOTHER'S MAIDEN NAME: Vera Mauger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Vera Buehm (mother) — Address: Stew 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Brain Tumor (inoperable) — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs
237 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 5-29-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5-31-61
22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY
22d. LOCATION (City, town, or country) (State): PRINCE GEORGES COUNTY, MD.

23. FUNERAL DIRECTOR: Francis J. Hodkin — ADDRESS: 3821-14th St. N.W. Wash, D.C.
24a. REC'D BY REGISTRAR: DATE JUN 1 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5750 Item 2 Film G287 5/24/61 jwk 05739

1. PLACE OF DEATH a. COUNTY: Montgomery — STATE: MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kensington Gardens Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Kensington~~ Bethesda 14

d. STREET ADDRESS: ~~3300 McComas Ave., Kensington, Md.~~ 4857 Battery Lane

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Ada	Kirk	Buffington	May	12	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White		Feb. 9, 1878	83 yrs.	3	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Josiah Kirk

14. MOTHER'S MAIDEN NAME: Anne Reynolds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give were or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Donald Dudley, 4857 Battery La., Beth. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonia	1 wk.
DUE TO (b)	Generalized Arteriosclerosis	10 yrs.
DUE TO (c)		

450.0

Conditions, if any, which geva rise to immediate ceuse (a), steting the underlying ceuse lest.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 1, 1961 to May 12, 1961, that (I) (we) last saw the deceased alive on May 12, 1961, and that death occured at 7:20 PM from the causes and on the date stated above.

22a. SIGNATURE: Dr Joseph Kenrick M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: May 13, 1961

22c. PHYSICIAN'S NAME (Type): Dr. Joseph Kenrick

22d. ADDRESS: 6450 Wisconsin Ave., Bethesda, Md.

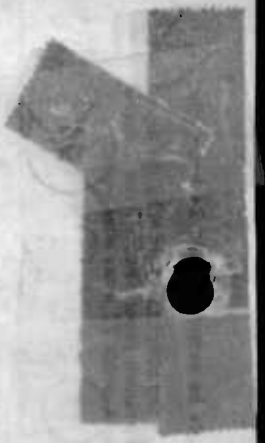
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial-transit	5-15-61	Brook View Cemetery	Rising Sun, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
ROBERT A. PUMPHREY	Bethesda, Md.	MAY 18 '61	Arthur L. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5751

CERTIFICATE OF DEATH

Reg. Dist. No. 05740

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Damascus
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 26720 Ridge Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Damascus
d. STREET ADDRESS: 26720 Ridge Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lolita Middle: Young Last: Burdette

4. DATE OF DEATH: Month: May Day: 9 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 28, 1880
9. AGE (In years lost birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Damascus, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Dallas Young
14. MOTHER'S MAIDEN NAME: Caroline Etchison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ----
INFORMANT: Mrs James Kent Dayn Address: Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion, acute, recurrent — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
420.1
DUE TO (b) Arteriosclerosis, generalized — 20 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus; cerbro-vascular accidents, multiple
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): none
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Jan 19, 1955 to May 9, 1961, that I last saw the deceased alive on May 9, 1961, and that death occurred at 12:53 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: G Meadors M.D.
ADDRESS (Street, city or town, state): Main Street
DATE SIGNED:
PHYSICIAN'S NAME (Type): Gilcin F. Meadors, M.D. Damascus, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 11, 1961
22c. NAME OF CEMETERY OR CREMATORY: Damascus Meth.
22d. LOCATION (City, town, or county) (State): Damascus, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Olen L. Wolsonth
ADDRESS: Damascus, Md.
24a. REC'D BY REGISTRAR DATE: MAY 12 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5752 — 05741

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 615 W. Lynfield Drive

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 615 W. Lynfield Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JUNE — Middle: E — Last: BURTON

4. DATE OF DEATH: Month: May — Day: 27 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 6/2/1925

9. AGE (In years last birthday): 35 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John S. Grillo

14. MOTHER'S MAIDEN NAME: Olympia Pascal

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: Richard Burton-Husband-same 2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC AND PULMONARY METASTASES — INTERVAL BETWEEN ONSET AND DEATH: 6 MOS
DUE TO (b): CARCINOMA OF BREAST — 28 MOS
DUE TO (c):

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from AUGUST, 19 60 to MAY 27, 19 61, that (I) (~~we~~) last saw the deceased alive on MAY 27, 19 61, and that death occured at 9:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: J H Tuohy M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/27/61

22c. PHYSICIAN'S NAME (Type): JOHN H. TUOHY, M.D.

22d. ADDRESS: 7720 WISCONSIN AVE BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/31/61

23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

25a. REC'D BY REGISTRAR — DATE: MAY 31 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5753

CERTIFICATE OF DEATH

05742

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 8018 Park Lane

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 8018 Park Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle R. Last CANADA
4. DATE OF DEATH: Month May Day 12, Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 26, 1897
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: George Donaldson
14. MOTHER'S MAIDEN NAME: Margaret Hickey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Daughter Mrs. D. A. Pampillonia 5920 Greentree Rd. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Failure. — INTERVAL BETWEEN ONSET AND DEATH

420.0

DUE TO (b) MyoCARDIAL Infarct —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerotic heart disease.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 1960 to Pr. resent 19..., that (I) (~~we~~) last saw the deceased alive on May 9 1961, and that death occured at 6:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Donald Q Ekman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/12/61
22c. PHYSICIAN'S NAME (Type): DONALD Q. EKMAN
22d. ADDRESS: 5707 Wisconsin Ave, Chevy Chase, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-15-61
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven
23d. LOCATION (City, town or county) (State): Silver Spring, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAY 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5754 05743

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Garrett Park
c. LENGTH OF STAY IN 1b: 24 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4419 Strathmore Ave

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont'g
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Garrett Park
d. STREET ADDRESS: 4419 Strathmore Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leslie — Middle: Maynard — Last: Cannon

4. DATE OF DEATH: Month: May — Day: 26 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-14-91
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (Unknown) King
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): No
16. SOCIAL SECURITY NO.: 579-01-3233
17. INFORMANT: Guilford Cannon (Husband) — Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b) Arteriosclerotic Heart Disease — 5 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of previous coronary disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 5-26-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/29/61
22c. NAME OF CEMETERY OR CREMATORY: George Wash. Cemetery
22d. LOCATION (City, town, or country) (State): Hyattsville, Maryland

23. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE MAY 31 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5755 — 45744

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 156 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Distrikt of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1420 Saratoga Avenue, N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

M — 050 — I

3. NAME OF DECEASED (Type or print): First: Paul — Middle: Arthur — Last: Carson

4. DATE OF DEATH: Month: May — Day: 24 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: January 3, 1904
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Unknown
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arthur Carson
14. MOTHER'S MAIDEN NAME: Carrie Gregg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 578-07-9202
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Congestion — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
141.9
DUE TO
(b) Metastatic Carcinoma — 3 weeks
DUE TO
(c) Epidermoid carcinoma of tongue — 10 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from December 19, 1960 to May 24, 1961, that I (we) last saw the deceased alive on May 24, 1961, and that death occurred at 9:55 p.m. from the causes and on the date stated above.

22a. SIGNATURE: David T. Crawford M.D. — M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5/25/61
22c. PHYSICIAN'S NAME (Type): DAVID T. CRAWFORD, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): burial
23b. DATE THEREOF: 5/27/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town, or county) (State): Pr.Geo.Co., Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co.,
ADDRESS: 2901 14th St. N.W., Wash,D.C.
25a. REC'D BY REGISTRAR DATE: MAY 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05745

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1341-E. Capitol St. S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Herman Middle Joseph Last Carter
4. DATE OF DEATH: Month May Day 19 Year 1961
5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 8, 1915
9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Awning Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Burton Awning Co.
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Leighton Carter
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): World War 2
16. SOCIAL SECURITY NO.: 577-05-2102
17. INFORMANT: Marjorie Carter — Address: 11- 35 th.St.S.E.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
DUE TO (b) Fracture of skull
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4½ hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell from ladder 24 ft while placing awnings
20c. TIME OF INJURY: Hour 2:34 p.m. Month, Day, Year 5-19 1961
20d. INJURY OCCURRED: While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Building
20f. (City or town) Chevy Chase (County) Monty (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-23-61
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l
22d. LOCATION (City, town, or country) Fox Hyner (State) Va

23. FUNERAL DIRECTOR: Robert A. Mattingly
ADDRESS: Wash. D.C. 131-11
24a. REC'D BY REGISTRAR: MAY 22 '61
DATE
24b. REGISTRAR'S SIGNATURE: Clifton L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 7/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5757

CERTIFICATE OF DEATH

05746

M

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 13 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BROOKEVILLE
d. STREET ADDRESS: (SUNSHINE)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

073

3. NAME OF DECEASED (Type or print): First: MONTGOMERY — Middle: WRIGHT — Last: CASHELL

4. DATE OF DEATH: Month: MAY — Day: 19, — Year: 19 61

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-15-1876
9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEORGE WASHINGTON CASHELL
14. MOTHER'S MAIDEN NAME: CATHERINE AUGUSTA HOBBS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: HOSPITAL RECORDS, OLNEY, MARYLAND — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mesenteric thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b):
DUE TO (c):

570.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis,

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/5/61 19__ to 5/19 19 61, that (I) (we) last saw the deceased alive on 5/17 19 61 and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: Richard A. Yates M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/19/61
22c. PHYSICIAN'S NAME (Type): R. A. YATES, M. D.
22d. ADDRESS: OLNEY, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-22-61
23c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
23d. LOCATION (City, town, or county) (State): Sunshine, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis K. Barber — ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR — DATE: MAY 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

5758

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05747

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA
c. LENGTH OF STAY IN 1b 1 Hr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4939 Cordell Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING
d. STREET ADDRESS 929 GIST AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M

3. NAME OF DECEASED (Type or print) First Ferdinand Middle P Last Cayelli
4. DATE OF DEATH Month MAY Day 11 Year 19 61
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH May 5, 1905
9. AGE (In years last birthday) 56 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer
10b. KIND OF BUSINESS OR INDUSTRY A.B. Engineering Co.
11. BIRTHPLACE (State or foreign country) Pennsylvania, Mason Town
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Daniel Cayelli Italy
14. MOTHER'S MAIDEN NAME Eletta Archangeli Italy
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -
16. SOCIAL SECURITY NO. 220-32-6779
17. INFORMANT Address 929 Gist Avenue Mrs. Nell R. Cayellie Silver Spring, Maryland

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, sudden — INTERVAL BETWEEN ONSET AND DEATH: sudden
4201
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): History of previous Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Franz J. Broschart M.D.
EXAMINER'S NAME (Type) Dr. Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5/11/61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF May 15, 1961
22c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven, Cemetery
22d. LOCATION (City, town, or county) (State) Montgomery Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. ADDRESS 8434 Georgia Avenue Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE MAY 17 '61
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5755

CERTIFICATE OF DEATH

05748

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring,
d. STREET ADDRESS: 8504 16th Street,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Chaikin

4. DATE OF DEATH: Month: May — Day: 26, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 25, 1961

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours: 19 — Min.: 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: America

13. FATHER'S NAME: George - Chaikin

14. MOTHER'S MAIDEN NAME: L. Judith Shapiro

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT: father — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Subdural & subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs.
DUE TO (b)
758.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Achondroplastic dwarfism — Congenital

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 25, 1961, to May 26, 1961, that (I) (we) last saw the deceased alive on May 25 1961, and that death occured at 7:50 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Sydney Leventhal, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 26, 1961

22c. PHYSICIAN'S NAME (Type): Sydney Leventhal, M.D.
22d. ADDRESS: 9210 Colesville Rd., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 6-3-61
23c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hospital, Takoma Park, Md.
23d. LOCATION (City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M.D.
ADDRESS: Washington San. & Hospital

25a. REC'D BY REGISTRAR DATE JUN 6 '61
25b. REGISTRAR'S SIGNATURE: Catherine S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5760

CERTIFICATE OF DEATH

Reg. Dist. No. 05749

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mollie Marvelle Middle: Last: Childs

4. DATE OF DEATH: Month: May Day: 3 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 21, 1881
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aden Allnutt
14. MOTHER'S MAIDEN NAME: Martha Duvall

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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. William Childs — Address: Derwood, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
DUE TO (b) Hypertensive Cardiovascular Disease — Yrs
DUE TO (c) Chronic Pyelonephritis — Yrs.

600.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 1950, to 5/3, 1961, that I last saw the deceased alive on 4/24, 1961, and that death occurred at 2:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. H. Ligon M.D.
ADDRESS (Street, city or town, state): Medical Center, Sandy Spring, Md.
DATE SIGNED: 5/3/61

PHYSICIAN'S NAME (Type): C. H. Ligon, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5-5-61
22c. NAME OF CEMETERY OR CREMATORY: St. John
22d. LOCATION (City, town, or county) (State): Olney, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber — ADDRESS: Laytonsville, Md.
24a. REC'D BY REGISTRAR: DATE MAY 8 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5761 **CERTIFICATE OF DEATH** 06896

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges (Howard)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jessup
d. STREET ADDRESS: Box 6, 13, X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: L.C. Middle: - Last: Christian Jr.
4. DATE OF DEATH: Month: May Day: 28, Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 28, 1961
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.: Approx
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: L.C. - Christian
14. MOTHER'S MAIDEN NAME: Peggy Ann Meade
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: father Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary atelectasis and emphysema
762.0
DUE TO
(b) Microscopic pulmonary pathology suspected
DUE TO
(c) (Microscopics to follow.)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occured at.....M, from the causes and on the date stated above.

22a. SIGNATURE: Donald Strauss M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-28-61
22c. PHYSICIAN'S NAME (Type): Donald Strauss, M. D.
22d. ADDRESS: 3400 May St., Silver Spring, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 5-29-61
23c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hospital, Takoma Park, Md.
23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M. D. ADDRESS: Wash. San. & Hospital
25a. REC'D BY REGISTRAR: DATE JUN 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2075 212XV5

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5762 — 65750

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): W. Hyattsville 1657-2
d. STREET ADDRESS: 1709 Lebanon ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael — Middle: Alexandee — Last: Codirenzi
4. DATE OF DEATH: Month: May — Day: 6 — Year: 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-12-15
9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Draftsman
10b. KIND OF BUSINESS OR INDUSTRY: D.C. Highway Dept
11. BIRTHPLACE (County & State, or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Codirenzi
14. MOTHER'S MAIDEN NAME: Grace Murgia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give year or dates of service)
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Compression BRAIN stem — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO (b): Cerebral oedema approx — 14 days
DUE TO (c): Suprasellar neoplasm estimated — 4 mos. +

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

195.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Suspected infarction left frontal lobe

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 4/25, 1961 to 5/6, 1961, that (I) (we) last saw the deceased alive on 5/5, 1961, and that death occurred at 4 A.M., from the causes and on the date stated above.

22a. SIGNATURE: John T. Lord M.D. — M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/6/61
22c. PHYSICIAN'S NAME (Type): John T. LORD
22d. ADDRESS: 1015 Spring Street, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MAY 9, 1961
23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN
23d. LOCATION (City, town or county) (State): Wheaton MD.

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Tattanell — ADDRESS: 3603 14th St NW
25a. REC'D BY REGISTRAR: DATE MAY 8 '61
25b. REGISTRAR'S SIGNATURE: Odine S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G290 7/14/61 iwk

5763

CERTIFICATE OF DEATH

Reg. Dist. No. 05751

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WHEATON NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON, D.C.
d. STREET ADDRESS: 2800 QUEBEC STREET, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First COL. SAMUEL; Middle FRANCIS; Last COHN

4. DATE OF DEATH: Month MAY; Day 25; Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 15, 1894

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Colonel

10b. KIND OF BUSINESS OR INDUSTRY: U.S. ARMY

11. BIRTHPLACE (State or foreign country): ~~NEBRASKA~~ Poland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MORRIS COHN

14. MOTHER'S MAIDEN NAME: BLUMA ---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): 1917-1953

16. SOCIAL SECURITY NO.:

INFORMANT: MRS. FLORENCE COHN — Address: 2800 QUEBEC ST., N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO
(b) Parkinson's Disease
DUE TO
(c) Diabetes · Carcinoma of prostate

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/23, 19 61 to 5/25, 19 61, that I last saw the deceased alive on 5/25, 19 61, and that death occurred at 3:20 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Jerome J. Krick M.D.

ADDRESS (Street, city or town, state): 2800 QUEBEC STREET, N.W.

DATE SIGNED

PHYSICIAN'S NAME (Type): JEROME J. KRICK, M.D.

WASHINGTON, 8, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5-29-61

22c. NAME OF CEMETERY ~~OR CREMATORY~~: ARLINGTON NATIONAL CEMETERY

22d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: BERNARD DANZANSKY & SONS — ADDRESS: 3501 14th St., NW

24a. REC'D BY REGISTRAR — DATE: MAY 31 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
FOR STATE HEALTH DEPT.

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TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MA3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5764

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05752

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4431 35th Street, N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Earl — Middle: Walter — Last: COOK
4. DATE OF DEATH: Month: May — Day: 29 — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-29-88
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Vincent R. COOK
14. MOTHER'S MAIDEN NAME: Mollie BROWN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWI&II
16. SOCIAL SECURITY NO.:
17. INFORMANT: (W() Mrs. Mertie I. Cook, same as #2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-29-61
EXAMINER'S NAME (Type): Frank J. BROSCHART, M. D.
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 6-2-61
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or country): Arlington — (State): Virginia

23. FUNERAL DIRECTOR: W. W. Chambers Co. — ADDRESS: W.W.Chambers Co.,3072 M St.,NW,Washington, D.C.
24a. REC'D BY REGISTRAR: DATE JUN 1 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

5765

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05753

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C. , b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4120 Military Road, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

074

4 7X-3

3. NAME OF DECEASED (Type or print): First: Mae; Middle: G; Last: Corey
4. DATE OF DEATH: Month: May; Day: 1; Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/24/71
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months | Days | Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N. Y
12. CITIZEN OF WHAT COUNTRY? Usa yes.
13. FATHER'S NAME: John Morey.
14. MOTHER'S MAIDEN NAME: Felicia Morey grandson.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Irving M. Tullar Address:

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Right hemiplegia with aphasia, severe — INTERVAL BETWEEN ONSET AND DEATH: 12 days
DUE TO
(b) Arteriosclerosis, generalised, advanced — 10 yrs +
DUE TO
(c) Essential hypertension, mod severe — 10 yrs +

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

334 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ ~~CAUSE OF DEATH~~ (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1946 to May 1 1961, that (I) (we) last saw the deceased alive on Apr 26 1961, and that death occurred at 5:50 AM, from the causes and on the date stated above.

22a. SIGNATURE: Stewart Clapp M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 1 61
22c. PHYSICIAN'S NAME (Type): Stewart Clapp
22d. ADDRESS: 4746 Chevy Chase Dr. Chevy Chase Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/3/61
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.
23d. LOCATION (City, town, or county) (State): Bladensburg Md

24. FUNERAL DIRECTOR'S SIGNATURE: Chevy Chase Funeral Home ADDRESS: 5703 Wisconsin Washington D.C.
25a. REC'D BY REGISTRAR DATE: MAY 4 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5766

CERTIFICATE OF DEATH

Reg. Dist. No. 05754

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville 06
d. STREET ADDRESS: Stoney Creek Road 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle E. Last CORNWELL

4. DATE OF DEATH: Month May Day 20 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/23/83
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: George W. Cornwell
14. MOTHER'S MAIDEN NAME: Sara Ann Kidwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-09-8113
INFORMANT: E. L. Cornwell Address: 306 W. Edmonston Drive Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH: months
151X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/16, 1961, to 5/20, 1961, that I last saw the deceased alive on 5/19, 1961, and that death occurred at 5:35 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): 927 Pershing Dr. DATE SIGNED: 5/20/61

PHYSICIAN'S NAME (Type): ABRAHAM W. DANISH [redacted], Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/23/61
22c. NAME OF CEMETERY OR CREMATORY: Forest Oak
22d. LOCATION (City, town, or county) (State): Gaithersburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home ADDRESS: 1331 E. Montg. Ave. Rockville, Md.
24a. REC'D BY REGISTRAR DATE MAY 23 '61
24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5767

CERTIFICATE OF DEATH

Reg. Dist. No. 05755

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 11118 NORLEE DR

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. b. COUNTY: MONTG.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 39 SILVER SPRING
d. STREET ADDRESS: 11118 NORLEE DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: MINNIE — Middle: M — Last: COZIER

4. DATE OF DEATH: Month: May — Day: 5 — Year: 1961

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐
8. DATE OF BIRTH: OCT-12-1884
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: LEBANON
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: IRWIN COZIER — Address: 11118 NORLEE DR SSTG MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma
DUE TO
(b) Pancreas
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

157X

INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan., 1959 to May 5, 1961, that I last saw the deceased alive on April 30, 1961, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Bernard Katzen M.D. — ADDRESS (Street, city or town, state): 3550 Minn. Ave. S.E. — DATE SIGNED: 5-5-61

PHYSICIAN'S NAME (Type): BERNARD KATZEN M.D. Wash. 19, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5/7/61
22c. NAME OF CEMETERY OR CREMATORY: SHARRE TORAH CEM
22d. LOCATION (City, town, or county) (State): PITTSBURGH, PA.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Gedling Funeral Home 4217-9th Ave
24a. REC'D BY REGISTRAR DATE: MAY 8 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5768

CERTIFICATE OF DEATH

05756

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: 47X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: The Dresden Apt. - 202 Conn. Ave. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: Margaret Elliott Craig

4. DATE OF DEATH: Month: May — Day: 12 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/1/80
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C. U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Elliott
14. MOTHER'S MAIDEN NAME: Eckernect?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mrs. W.A. Rogers — Address: 5910 - Goshen Rd. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Extensive Anterior Wall Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
420-1
DUE TO (b): Coronary Atherosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/9, 1961 to 5/12, 1961, that (I) (we) last saw the deceased alive on 5/12 1961, and that death occured at 11 A.M. from the causes and on the date stated above.

22e. SIGNATURE: Michel M. Healy M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/12/61
22c. PHYSICIAN'S NAME (Type): MICHEL M. HEALY
22d. ADDRESS: Washington Clinic Washington 15, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-16-61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE: R.A. Humphrey Funeral Home — ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR — DATE: MAY 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Copies 3 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5769 Item 7 Film G287 5/18/61 jwk 05757

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 45 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4027 Plyers Mill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: ; Last: Crockett
4. DATE OF DEATH: Month: 5; Day: 10; Year: 1961
5. SEX: male
6. COLOR OR RACE: colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/8/08
9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): New York State
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Samuel Crockett
14. MOTHER'S MAIDEN NAME: Carolyn ———
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO. (If yes give were or dates of service):
17. INFORMANT: Bernice A. Crockett, Wife Address: 327 S. Maplewood Chicago, Ill.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Confluent bronchopneumonia — 10d

DUE TO (b) Multiple Emboli, Brain, Kidney — 2 months

DUE TO (c) Myocardial Infarction & Mural thrombi — 2 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on 9 May 1961, and that death occured at.....M, from the causes and on the date stated above.

22a. SIGNATURE: Merton L. White M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10 May '61
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS: 11134 Georgia Ave Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/15/61
23c. NAME OF CEMETERY OR CREMATORY: Ash Memorial
23d. LOCATION (City, town or county) (State): Sandy Spring, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden
ADDRESS: Rockville, Md.
25a. REGISTRAR REGISTERS DATE MAY 15 '61
25b. REGISTRAR'S SIGNATURE: Carlton L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Complicated Hemorrhagic Pneumonia 104
Multiple Emboli, Brain, Kidney & Pancreatic
Hyperadrenal Infarction & Mural Thrombi, Zenker's

1

FOR STATE HEALTH DEPT.

M.

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5770

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05758

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: F.D.A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 10531 - Oxkhyn Drive.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mathias — Middle: — Last: Curtis.

4. DATE OF DEATH: Month: May — Day: 24 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 15, 1890

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer (Ret.)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Curtis

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes give war or dates of service): World War I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Lillian Williams — Address: Same as Above.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): History of previous coronary disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):

DATE SIGNED: 5-24-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/31/61

22c. NAME OF CEMETERY OR CREMATORY: Arlington National,

22d. LOCATION (City, town, or country) (State): Arlington, Va.

23. FUNERAL DIRECTOR: Robert L. Bracken — ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR DATE: MAY 29 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kenna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, may is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5771

CERTIFICATE OF DEATH

05759

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5300 Sherrill Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 5300 Sherrill Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BESSIE — Middle ANN — Last CUSICK

4. DATE OF DEATH: Month May — Day 4 — Year 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 22, 1881
9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months 6, Days 12 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: --------
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas D. Ross
14. MOTHER'S MAIDEN NAME: Ida Wood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give were or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: June C. Dowdall-daughter-same 2d — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 4 mo.
DUE TO (b) Primary Cancer of Stomach — 1 yr.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

15/X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Cardiovascular Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 15, 1960 to May 4, 1961, that (I) (we) last saw the deceased alive on May 3 1961, and that death occured at 5 AM, from the causes and on the date stated above.

22a. SIGNATURE: John R. Ewan M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-4-61
22c. PHYSICIAN'S NAME (Type): JOHN R. EWAN-M.D
22d. ADDRESS: 1835 Eye St. N.W. Wash. 6, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/8/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAY 5 '61
25b. REGISTRAR'S SIGNATURE: Clinton L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

I

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5772

CERTIFICATE OF DEATH

05760

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 24 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia — b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria

d. STREET ADDRESS: 10 Chinquapin Drive

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Beulah — Middle: May — Last: Davies

4. DATE OF DEATH: Month: May — Day: 11 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: September 19, 1900

9. AGE (In years lost birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John W. Holsinger

14. MOTHER'S MAIDEN NAME: Minnie Mason

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unascertainable

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

DUE TO (b) Hypertensive CVD — 5 years

DUE TO (c) Myasthenia Gravis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

744.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 17, 1961, to May 11, 1961, that (I) (we) last saw the deceased alive on May 11, 1961, and that death occurred at 11:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: David A. Drachman M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5-12-61

22c. PHYSICIAN'S NAME (Type): David A. Drachman

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 15, 1961

23c. NAME OF CEMETERY OR CREMATORY: Mount Comfort

23d. LOCATION (City, town, or county) (State): Fairfax Co. Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: A. Beverly Mountcastle — Funeral Director — ADDRESS: P. O. Box 65 Alexandria, Va.

25a. REC'D BY REGISTRAR DATE: MAY 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5773 **CERTIFICATE OF DEATH** 05761

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 36 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3313 16th Street, N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Louis — Last: DEGNAN
4. DATE OF DEATH: Month: May — Day: 16 — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-5-94
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Admin. Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Maritime Comm.
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Thomas Degnan
14. MOTHER'S MAIDEN NAME: Mary O'Brien

I

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): 1918 to 1919
16. SOCIAL SECURITY NO.: 579-24-1707 (B)
17. INFORMANT: Geo. Degnan — Address: 3513 S St., NW, WashDC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma tongue with metastasis — INTERVAL BETWEEN ONSET AND DEATH: 2½ yrs.
141.9
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (☒ (this hospital) attended the deceased from April 10, 1961 to May 16, 1961, that (☒ (we) last saw the deceased alive on May 16 1961, and that death occured at 7:40 AM, from the causes and on the date stated above.

22a. SIGNATURE: T. E. Taylor M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-16-61
22c. PHYSICIAN'S NAME (Type): T. E. TAYLOR, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-19-61
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: H. Don DeVol — ADDRESS: DeVol Funeral Home, 2224 Wisconsin Ave., NW, WashDC
25a. REC'D BY REGISTRAR: MAY 18 61 — DATE
25b. REGISTRAR'S SIGNATURE: Arthur J. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Montgomery District of Columbia

Bethesda (Burial) 36 days Washington

U. S. Naval Hospital 3213 16th Street, N. W.

Thomas Louis DENMAN May 16 61

x

Male Caucasian 6-3-34 66

Admin. Clerk Maritime Comm. Pennsylvania USA

Thomas Denman Mary O'Brien

Yes Join to 1919 7-19-44-17 (R) Geo. Denman, 3513 S St.,NW,WashDC

x

x

May 16 61 April 10 61 May 16 61 x

7:40AM

x 5-10-61

T. E. TAYLOR, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

Burial 5-19-61 Arlington National Arlington Virginia

WashDC

DeVol Funeral Home, 2224 Wisconsin Ave.,NW,

1

5774

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05762

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Echo
c. LENGTH OF STAY IN 1b: 16 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 11 Vassar Circle

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Echo 58
d. STREET ADDRESS: 11 Vassar Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alfred — Middle: James — Last: DePaolis

4. DATE OF DEATH: Month: May — Day: 18 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Apr 25 1899

9. AGE (In years lost birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber

10b. KIND OF BUSINESS OR INDUSTRY: Barber Shop

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Giovani DePaolis

14. MOTHER'S MAIDEN NAME: Louisa Bonbino

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578010028

INFORMANT: Louis DePaolis — Address: 11 Vassar Cr Glen Echo Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metestatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.
DUE TO (b): Carcinoma pancreas. — 9 mo.
DUE TO (c):

157X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 31, 1960 to May 18, 1961, that I last saw the deceased alive on May 17, 1961, and that death occurred at 2:15 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE E. E. Quayle M.D. — **ADDRESS** (Street, city or town, state) 1822 Belmont Rd. N.W. Wash. D.C. — **DATE SIGNED**

PHYSICIAN'S NAME (Type) E. E. Quayle M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: May 22, 1961

22c. NAME OF CEMETERY OR CREMATORY: National Memorial Park

22d. LOCATION (City, town, or county) (State): Falls Church, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: H. Don. DE Vol — **ADDRESS**: 2224 Wis Ave Wash. DC

24a. REC'D BY REGISTRAR DATE MAY 23 '61

24b. REGISTRAR'S SIGNATURE: Clothilde S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

5775

WT. 1 lb 7 oz 12 inch, long.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 06908

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DISTRICT OF COLUMBIA — b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 57 WASHINGTON 16
d. STREET ADDRESS: 5723 OGDEN Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

M (C) 074

3. NAME OF DECEASED (Type or print): First: BABY — Middle: GIRL — Last: DERRY

4. DATE OF DEATH: Month: MAY — Day: 25 — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 23, 1961

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: Days: 2 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN ALVIN DERRY

14. MOTHER'S MAIDEN NAME: MILDRED VIRGINIA KRIEG

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MOTHER — Address: SAME AS ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PREMATURITY
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

776X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

2

21. I certify that I attended the deceased from 5/23, 1961, to 5/25, 1961, that I last saw the deceased alive on 5/25, 1961, and that death accurred at 3:55 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Jean Pendleton M.D.
ADDRESS (Street, city or town, state)
DATE SIGNED
PHYSICIAN'S NAME (Type)

1

22a. BURIAL, CREMATION, REMOVAL (Specify): cremation — **22b. DATE THEREOF**: 5/27/61 — **22c. NAME OF CEMETERY OR CREMATORY**: SUBURBAN HOSPITAL — **22d. LOCATION** (City, town, or county) (State): BETHESDA, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Amelia Carter/p.p. — ADDRESS: OLD GEORGETOWN RD, BETHESDA, MARYLAND

24a. REC'D BY REGISTRAR DATE JUN 12 '61 — **24b. REGISTRAR'S SIGNATURE**: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BP

2074411XVO

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5776

CERTIFICATE OF DEATH

05763

1 M

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BELTSVILLE
d. STREET ADDRESS: 4501 BRANDON LANE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1674-2

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: Irene — Last: Dodd

4. DATE OF DEATH: Month: MAY — Day: 18 — Year: 1961 — 7:55 pm

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 9 1881

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SEAMSTRESS - HSWF.

10b. KIND OF BUSINESS OR INDUSTRY: PRIVATE

11. BIRTHPLACE (County & State, or foreign country): No. Thumberland Co., Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: UNKNOWN? - BRYANT

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: William H. Richards (son) — Address: as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Irreversable shock — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO (b): Pulmonary embolism — 2 hours
DUE TO (c): Peripheral Venous Thrombosis — unknown

466X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/16, 1961, to 5/18, 1961, that (I) (we) last saw the deceased alive on 5/18 1961, and that death occured at 7:55 P.M, from the causes and on the date stated above.

22a. SIGNATURE: A W Danish M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/19/61

22c. PHYSICIAN'S NAME (Type): ABRAHAM W DANISH

22d. ADDRESS: 927 Pershing Dr. Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 22, 1961

23c. NAME OF CEMETERY OR CREMATORY: George Washington Cem Inc

23d. LOCATION (City, town or county) (State): Hyattsville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: W. M. Chambers — **ADDRESS**: Clar. Co. Md.

25a. REC'D BY REGISTRAR — DATE: MAY 22 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Copy 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5777 **CERTIFICATE OF DEATH** 05764

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park Md
c. LENGTH OF STAY IN 1b: 3 WKS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. & Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md.
d. STREET ADDRESS: 8119 Hammond ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

075

3. NAME OF DECEASED (Type or print): First: Mrs Stella — Middle: Viretta — Last: Dodd
4. DATE OF DEATH: Month: 5 — Day: 1 — Year: 1961
5. SEX: Fe
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/6/74
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWF
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): OHIO
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles patton
14. MOTHER'S MAIDEN NAME: Elizabeth Coler
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Chart Record at Hospital. Address:

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
491X

INTERVAL BETWEEN ONSET AND DEATH: 2 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 2/8, 1961, to 5/1, 1961, that (I) (~~we~~) last saw the deceased alive on 5/1, 1961, and that death occured at 10:42 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Eino Magi, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/1/61
22c. PHYSICIAN'S NAME (Type): EINO MAGI
22d. ADDRESS: 918 Univ. Blvd. E., Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/3/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town or county) (State): Suitland Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Frank Geiers Sons Co
ADDRESS: 3605-14 St N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE MAY 3 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5778 — 65765

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. + Hosp.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery (Prince Georges)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md. 16542
d. STREET ADDRESS: 7804 Lockney Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louis — Middle: Michael — Last: Dorsch
4. DATE OF DEATH: Month: 5 — Day: 4 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-8-79
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: Bakery
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Michael Dorsch
14. MOTHER'S MAIDEN NAME: Catherine (unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown) (If yes give were or dates of service): No
16. SOCIAL SECURITY NO.: 578-09-6745
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edma — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.
DUE TO (b) Myocardial Insufficiency — 3 hrs.
DUE TO (c) Old Coronary Occlusion due to Arteriosclerosis?
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Supra-Pubic Prostatectomy 5-3-61
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this physician)~~ attended the deceased from April 10 to May 4, 1961, that (I) saw the deceased alive on May 4 19 61, and that death occured at 1:00 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Paul Efanet M.D.
22b. DATE SIGNED: 5-4-61
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): PAUL EFANET
22d. ADDRESS: 6727-16th St. N.W. WASH DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 8, 1961
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince George County Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska — ADDRESS: Warner E. Pumphrey Inc. Silver Spring Md.
25a. REC'D BY REGISTRAR — DATE MAY 9 '61
25b. REGISTRAR'S SIGNATURE: Clarence S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5779

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05766

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 6 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1910 Rockland Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1910 Rockland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alyse — Middle: Margaret — Last: Dougherty
4. DATE OF DEATH: Month: May — Day: 22 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-30-1897
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown Clark Richmond, Va.
14. MOTHER'S MAIDEN NAME: Margaret Unknown Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Jas. Jos Dougherty (Husband) — Address: Stew 2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Carcinoma of lower bowel with metastasis — 6 yrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
153.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 5-22-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
22b. DATE THEREOF: May 26, 1961
22c. NAME OF CEMETERY OR CREMATORY: West Laurel Hills Cemetery
22d. LOCATION (City, town, or country) (State): Montgomery County, Philadelphia

23. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Avenue Silver Spring, Md.
Raymond A Zokor
24a. REC'D BY REGISTRAR: DATE MAY 26 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5780

CERTIFICATE OF DEATH

65767

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cabin John
c. LENGTH OF STAY IN 1b: 50 year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6806 7 Locks Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 6806 - 7 Locks Rd
d. STREET ADDRESS: Cabin John
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ida — Middle: Ellen — Last: Dove
4. DATE OF DEATH: Month: May — Day: 13 — Year: 1961
5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 20, 1894
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Floyd T Jackson
14. MOTHER'S MAIDEN NAME: Not Known
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Fereya Snowden Dove — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial Infarct	Immediate
DUE TO (b)	Coronary Arteriosclerosis	5 years
DUE TO (c)	Arteriosclerotic Heart Disease	5 years

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept 1961 to May 13 1961, that (I) (we) last saw the deceased alive on May 11 1961, and that death occurred at 3.45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: William Henry Killay M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): William H Killay
22d. ADDRESS: 8218 Wisconsin Ave Bethesda

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/17/61
23c. NAME OF CEMETERY OR CREMATORY: Moses Cemetery.
23d. LOCATION (City, town, or county) (State): Cabin John, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden
ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR DATE MAY 19 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITALS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

5781

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

u5768

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Germantown
c. LENGTH OF STAY IN 1b: 20 yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Germantown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARTHA Middle ELLEN Last DOVE

4. DATE OF DEATH: Month MAY Day 13 Year 1961

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-28-1884
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Sanford R. Miller
14. MOTHER'S MAIDEN NAME: Virginia (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: Mr. Woodrow Dove, Gaithersburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATO-RENAL FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 3 WEEKS.
DUE TO
(b) METASTATIC CARCINOMA — 6 MONTHS ~~1 YEAR~~
DUE TO
(c) CARCINOMA OF THE STOMACH — 1 YEAR

151X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): LEFT HEMIPLEGIA HYPERTENSION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1949 to May 13, 1961, that (I) (we) last saw the deceased alive on 12 MAY 1961, and that death occurred at 10AM, from the causes and on the date stated above.

22a. SIGNATURE: John Fawcett M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): John Fawcett
22d. ADDRESS: DAWSONVILLE P.O. Boyd, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 16, 1961
23c. NAME OF CEMETERY OR CREMATORY: St. Luke's Lutheran
23d. LOCATION (City, town, or county) (State): Montgomery Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber
ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE MAY 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5782 **CERTIFICATE OF DEATH** 05769

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6608 Rannoch Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALLACE Middle J Last DUGAS
4. DATE OF DEATH: Month MAY Day 22 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/29/10
9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Br. Mgr.
10b. KIND OF BUSINESS OR INDUSTRY: Frick Co.
11. BIRTHPLACE (County & State, or foreign country): Louisiana
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Ernest Dugas
14. MOTHER'S MAIDEN NAME: Celina Daigel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Isabella Dugas Wife Address (Same as above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarct. Art — INTERVAL BETWEEN ONSET AND DEATH: 3½ days
420.1
DUE TO (b) Moderate Arteriosclerosis — 5 years
DUE TO (c) Moderate hypertension — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Fibrotic Emphysema & Asthma
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 18, 1961, to May 22, 1961, that (I) (we) last saw the deceased alive on May 21 1961, and that death occured at 9:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: Gilbert B Rude M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-22-61
22c. PHYSICIAN'S NAME (Type): Gilbert B. Rude
22d. ADDRESS: 3900 Military rd N W DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/25/61
23c. NAME OF CEMETERY OR CREMATORY: Burns Hill Cemetery
23d. LOCATION (City, town or county) (State): Waynsboro, Pennsylvania

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAY 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5783 65770

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 12 hrs. 10 min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Dist. of Co.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47 X-3
d. STREET ADDRESS: 3117-45th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE Middle HARRISON DURAND
DATE OF DEATH: Month May Day 19 Year 1961
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/31/1868
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher
10b. KIND OF BUSINESS OR INDUSTRY: YANKTON COLLEGE South Dakota
11. BIRTHPLACE (County & State, or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Cyrus Yale Durand
14. MOTHER'S MAIDEN NAME: Emma Celia C. Day
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown): no (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Harrison F. Durand, son, 160 Woodcrest Short Hills N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Circulatory Failure — INTERVAL BETWEEN ONSET AND DEATH: Several days
DUE TO (b): Coronary Atherosclerotic Heart Disease — Hypertension
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August, 1953 to May 19, 1961, that (I) ~~(we)~~ last saw the deceased alive on May 19 1961, and that death occured at 5:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Michael N. Healy M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/19/61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Washington Clinic Washington D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 5/22/61
23c. NAME OF CEMETERY OR CREMATORY: Yankton Cemetery
23d. LOCATION (City, town or county) (State): Yankton South Dakota

24 FUNERAL DIRECTOR'S SIGNATURE: S.H. Hines Co
ADDRESS: 2901-14th St. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: MAY 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5784 Reg. Dist. No. 05771

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11013 Montrose Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrett Park
d. STREET ADDRESS 11013 Montrose Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First LEON Middle Lamar Last DYE
4. DATE OF DEATH Month May Day 20, Year 19 61
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Nov. 21, 1871
9. AGE (In years on last birthday) 89 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retird
10b. KIND OF BUSINESS OR INDUSTRY Major USMC
11. BIRTHPLACE (State or foreign country) Miss.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Jefferson Dye
14. MOTHER'S MAIDEN NAME Leticia Longmire
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1 and 2
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Bethesda, Md. Williston L. Dye-son-9709 Bellevue Drive

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Frank J. Broschart M.D.
EXAMINER'S NAME (Type) Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5-20-61

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 5/24/61
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.
22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE MAY 23 '61
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data are not available, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5785 — 05772

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 25 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X SPENCERVILLE
d. STREET ADDRESS: 1 -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ADOLPHUS — Middle: (NMN) — Last: EDWARDS

4. DATE OF DEATH: Month: MAY — Day: 6 — Year: 19 61

5. SEX: MALE
6. COLOR OR RACE: COLORED
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-11-92
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CUSTODIAN
10b. KIND OF BUSINESS OR INDUSTRY: MONTG.CO. BD. OF EDUCATION
11. BIRTHPLACE (State or foreign country): NEBRASKA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JAMES EDWARDS
14. MOTHER'S MAIDEN NAME: MATTIE JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: HOSPITAL RECORDS — Address: OLNEY, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary and Cerebral Emboli — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
420.1
DUE TO
(b) Mural thrombus — 1) 3 wks
DUE TO
(c) Myocardial Infarction — 2) 3 months.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from APRIL 11, 19 61 to MAY 6, 1961, that (I) (we) last saw the deceased alive on MAY 6, 19 61, and that death occurred at 12:40 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Richard A. Yates M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/6/61
22c. PHYSICIAN'S NAME (Type): R.A. YATES, M.D.
22d. ADDRESS: OLNEY, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/10/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington National.,
23d. LOCATION (City, town, or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Surowden
ADDRESS: Rockville, Md.
25a. RECD BY REGISTRAR: MAY 10 '61
DATE: MAY 10 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Flaum

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5786

CERTIFICATE OF DEATH

05773

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 311 Ethan Allen Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Edward — Last: Edwards
4. DATE OF DEATH: Month: 5 — Day: 9 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-17-73
9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: John Edwards
14. MOTHER'S MAIDEN NAME: —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hosp record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema
DUE TO (b): Congestive heart failure
DUE TO (c): Arteriosclerotic heart disease

420.0

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/29, 1961, to 5/9, 1961, that (I) ~~(we)~~ last saw the deceased alive on 5/9 1961, and that death occured at 6:15 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Eino Magi, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/9/61
22c. PHYSICIAN'S NAME (Type): EINO MAGI
22d. ADDRESS: 918 Univ. Blvd. E., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 12, 1961
23c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery
23d. LOCATION (City, town or county) (State): Prince George County, Md.
24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St NW D.C.
25a. REC'D BY REGISTRAR DATE MAY 12 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

5787

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

65774

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 10 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookeville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Roland — Middle Mason — Last Fennington

4. DATE OF DEATH: Month May — Day 13 — Year 19 61

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/5/1888
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Heavy Construction
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Fennington
14. MOTHER'S MAIDEN NAME: Annie Nicholson Huff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs. Russell Bryan — Address: Brookeville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) Blood loss shock (internal bleeding) — INTERVAL BETWEEN ONSET AND DEATH: 2 days
422.1
DUE TO
(b) Probable rupture of abd. aortic aneurysm
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c) Arteriosclerotic Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/13/ 19 61, to 5/13 19 61 that (I) (we) last saw the deceased alive on 5/13 19 61 and that death occurred at 4:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John P. Martin MD — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 14 - 1961
22c. PHYSICIAN'S NAME (Type): JOHN P. MARTIN, MD
22d. ADDRESS: SANDY SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 17, 1961
23c. NAME OF CEMETERY OR CREMATORY: Brookeville
23d. LOCATION (City, town, or county) (State): Brookeville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber — ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE MAY 16 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5788

CERTIFICATE OF DEATH

05775

Item 6 Film G286 5/11/61 iwk

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Resmor Sanitarium, 5721 Grosvenor La.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington. 47 X 3
d. STREET ADDRESS: 4118 49th St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth; Middle: T.; Last: Fisher.

4. DATE OF DEATH: Month: May; Day: 6; Year: 1961

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 18 1878

9. AGE (In years lost birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SECRETARY

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? A.U.S.

13. FATHER'S NAME: George F. Fisher

14. MOTHER'S MAIDEN NAME: Mary E. Orr

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: John W. Fisher, Address: 4118 49th St, NW

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 22 mo
DUE TO (b) Generalized arteriosclerosis — years
DUE TO (c)

332 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 24, 1961, to May 5, 1961, that (I) (we) last saw the deceased alive on May 5 1961, and that death occurred at 10:55 AM from the causes and on the date stated above.

22a. SIGNATURE: C P Ryland M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-6-61

22c. PHYSICIAN'S NAME (Type): C. P. RYLAND

22d. ADDRESS: 4400-49 St NW Washington 16 DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/10/1961

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

23d. LOCATION (City, town, or county) (State): Washington, Iowa

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons, ADDRESS: Washington, D. C.

25a. REC'D BY REGISTRAR DATE: MAY 9 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

1

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5789

65776

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 16 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. + Hospital

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 8600 Greenwood Ave 19
d. STREET ADDRESS: Takoma Park 12 Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur Middle: Garfield Last: Fowler

4. DATE OF DEATH: Month: May Day: 19 Year: 1961

5. SEX: Male

6. COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-27-81

9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months 10 Days 22 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired machinist

10b. KIND OF BUSINESS OR INDUSTRY: BULLARD MFG. Co.

11. BIRTHPLACE (County & State, or foreign country): New York.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George W. Fowler

14. MOTHER'S MAIDEN NAME: ~~Frances Phelps~~ KATHERINE BURNS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give year or dates of service)

16. SOCIAL SECURITY NO.: 041-10-0131

17. INFORMANT: W.S. Hosp. Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Emphysema ; Chronic lung disease — years
DUE TO (c):

5271

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-6, 1957, to 5/19, 1961, that (I) (we) last saw the deceased alive on MAY 19 1961, and that death occured at 12:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE: G. Leonard Gold M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/19/61

22c. PHYSICIAN'S NAME (Type): G. Leonard Gold

22d. ADDRESS: 8641 Colesville Road, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 5/22/61

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Lawncroft Cemetery

23d. LOCATION (City, town or county) (State): Fairfield Connecticut

24. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc. Raymond A Ziska

ADDRESS: 8434 Georgia Ave, Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE MAY 23 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5790

CERTIFICATE OF DEATH

05777

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 11mo 23da
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Alta Vista Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Montana
b. COUNTY: Lewis & Clark
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Helena
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

63X-3

090

3. NAME OF DECEASED (Type or print): First: Jennie — Middle: W — Last: Graham

4. DATE OF DEATH: Month: May — Day: 31 — Year: 1961

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan 31 1878
9. AGE (In years lost birthday): 83 yrs. — IF UNDER 1 YEAR: Months 4, Days — IF UNDER 24 HRS.: Hours, Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. W.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John Whyatt
14. MOTHER'S MAIDEN NAME: Jane Seldon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: James D. Graham, Jr. — Address: 6007 Goldsboro Rd Bethesda, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks
DUE TO (b) Carcinomatosis generalized — 3 months
DUE TO (c) Adenocarcinomatosis of breast left — unknown

170 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour o. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1960 to 31 May 1961 that (I) (we) last saw the deceased alive on 27 May 1961, and that death occurred at 9:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Herbert Martyn Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 31 May 61
22c. PHYSICIAN'S NAME (Type): HERBERT MARTYN JR
22d. ADDRESS: 5029 Bethesda Ave

23a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
23b. DATE THEREOF: 6/1/61
23c. NAME OF CEMETERY OR CREMATORY: Mountain View Cem.
23d. LOCATION (City, town, or county) (State): Livingston, Montana

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: JUN 2 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5791 — 65778

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 4605 Wilwyn Way

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: Box 52
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara — Middle: Angeline — Last: Griffith
4. DATE OF DEATH: Month: May — Day: 30 — Year: 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 19, 1866
9. AGE (In years last birthday): 94 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Post mistress, ret
10b. KIND OF BUSINESS OR INDUSTRY: Post Office
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: David Porter Griffith
14. MOTHER'S MAIDEN NAME: Margaret Virginia Keys
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give were or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: Ruth G. Veirs-Box 52-Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years
422.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): cerebrovascular accident - cerebral thrombosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): NONE
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct. 17, 1957 to May 30, 1961, that (I) (~~we~~) last saw the deceased alive on May 29 1961, and that death occured at 12 AM, from the causes and on the date stated above.

22a. SIGNATURE: Stephen C. Cromwell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-30-61
22c. PHYSICIAN'S NAME (Type): Stephen C. Cromwell
22d. ADDRESS: Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/1/61
23c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE JUN 2 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5792

CERTIFICATE OF DEATH

05779

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1½ hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3932 Morrison St, NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Armand — Middle: Llewellyn — Last: Griggs

4. DATE OF DEATH: Month: May — Day: 27 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 8, 1909

9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meteorologist

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Weather Bur.

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Irving Griggs

14. MOTHER'S MAIDEN NAME: Altah Schindler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown) (If yes give were or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Eliz. Griggs — Address: AS ABOVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Thrombosis, Right Coronary Artery
DUE TO (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/27/61, 1961, to 5/27/61, 1961, that (I) (we) last saw the deceased alive on 5/27/61, 1961, and that death occured at 6:22 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Stephen R. Jones M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/27/61

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 5/30/61

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory

23d. LOCATION (City, town or county) (State): Prince Georges County, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zibka

ADDRESS: Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE: JUN 6 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5793

CERTIFICATE OF DEATH

Reg. Dist. No. 05781

M

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK

c. LENGTH OF STAY IN 1b: 57 days.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: PENNA b. COUNTY:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lewisburg.

d. STREET ADDRESS: 75 X-3

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

075

3. NAME OF DECEASED (Type or print): First MARY Middle JANE Last GROOVER

4. DATE OF DEATH: Month 5 Day 29 Year 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 10.26.83

9. AGE (In years lost birthday): 77 yrs.

IF UNDER 1 YEAR: Months 7 Days 3 IF UNDER 24 HRS.: Hours Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home-maker

11. BIRTHPLACE (State or foreign country): PENNA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: J. Gundy Wolfe

14. MOTHER'S MAIDEN NAME: Anna Baker.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Address: WASHINGTON SANITARIUM & HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Lymphoma Abdominal (Hodgkins)

DUE TO (b)

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

201 X

INTERVAL BETWEEN ONSET AND DEATH (a) —

Some possibility 6 3/4 Months Definite known as Surgery, Apr 1961

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/30/1947 to 5/29/1961, that I last saw the deceased alive on 5/29/1961, and that death occurred at 10:25 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Howard T. Morse M.D. ADDRESS (Street, city or town, state): 7030 Carroll Ave. Takoma Park Md DATE SIGNED: 5/29/61

PHYSICIAN'S NAME (Type): HOWARD T. MORSE

1

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5/29/1961

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State): LEWISBURG, PENNSYLVANIA

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HYSONG FUNERAL HOME 1300 N. STREET, N.W. WASHINGTON, D.C.

Hysong Funeral Home

Chas. G. Hysong

24a. REC'D BY REGISTRAR DATE MAY 31 '61

24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5794 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05781

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 2410 No 11th ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Linda Middle: Lee Last: Haas
4. DATE OF DEATH: Month: 5 Day: 31 Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Separated
8. DATE OF BIRTH: 5-23-08
9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: N.O.L.
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Robert Lee Cheely
14. MOTHER'S MAIDEN NAME: Linda Hawks.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mr. R.V. Jones - Same Address Address: Brother in law

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH days

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) SEVERE CORONARY ARTERY ARTERIOSLEROSIS WITH THROMBOSIS days

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 5-31-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 6-3-61
22c. NAME OF CEMETERY OR CREMATORY: COLUMBIA GARDENS
22d. LOCATION (City, town, or country) (State): ARLINGTON, VA
23. FUNERAL DIRECTOR: IVES FUNERAL HOME, INC. ADDRESS: ARLINGTON, VA.
24a. REC'D BY REGISTRAR DATE JUN 5 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5795

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05782

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): W. Franklin St.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1 W. Franklin St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William ~~Colon~~ COLON; Last: Hall
4. DATE OF DEATH: Month 5; Day 28; Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN 11, 1891
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONSTRUCTION WORKER
10b. KIND OF BUSINESS OR INDUSTRY: self-employed
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Mr. William Thomas Hall — Maryland
14. MOTHER'S MAIDEN NAME: Mrs. Susan Tippett — Maryland
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 579-03-7467
17. INFORMANT: Mrs. Helen N. Hall, 5645 Govane Avenue, Baltimore, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b) Mucoid Obstruction of Bronchi — Sudden
DUE TO (c) Confluent Bronchopneumonia — Unknown

491 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 5-29-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/31/61
22c. NAME OF CEMETERY OR CREMATORY: New Cathedral Cemetery
22d. LOCATION (City, town, or country) (State): Baltimore, Maryland
23. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc., ADDRESS: 8434 Georgia Avenue, Silver Spring, Maryland
Raymond A. Zielka
24a. REC'D BY REGISTRAR: DATE JUN 5 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

1

FOR STATE HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5796

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 13 & 14 Film 0288 6/15/61 jwk

05783

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2 wks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 723 Bonndy Ave

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Silver Spring
d. STREET ADDRESS: 1723 Bonndry Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel Middle: Homer Last: Hamblin

4. DATE OF DEATH Month: May Day: 21 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 9- -1911
9. AGE (In years last birthday): 49 yr.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va (Pulaski County)
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 224-10-5050
17. INFORMANT Address: MRS HELEN NESTER HAMBLIN (wife) c/o Devilbliss Funeral Home, Radford Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

INTERVAL BETWEEN ONSET AND DEATH: Found dead on floor at home

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Frank J. Broschart M.D.
EXAMINER'S NAME (Type) FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED 5-21-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5/24/61
22c. NAME OF CEMETERY OR CREMATORY: SIFFORD CEMETERY
22d. LOCATION (City, town, or country) (State): PULASKI COUNTY, VA.

23. FUNERAL DIRECTOR: Warner E. Pumphrey Inc
ADDRESS: 5434 Georgia Ave S.S. Wed.
24a. REC'D BY REGISTRAR DATE: MAY 23 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5797

CERTIFICATE OF DEATH

05784

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4727 Boiling Brook Pkwy.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia — b. COUNTY: Harrison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg
d. STREET ADDRESS: 85 X-
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

X

3. NAME OF DECEASED (Type or print): First: Lot — Middle: P — Last: Hansford
4. DATE OF DEATH: Month: May — Day: 24 — Year: 19 61

I

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 18, 1877
9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months: 3 — Days: 6
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gas Company
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis H. Hansford
14. MOTHER'S MAIDEN NAME: Victoria Barnette

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Louise Osborne-Daughter-same ld — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 3 MOS
DUE TO
(b) PROSTATIC HYPERTROPHY — 2 YEARS
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

610X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from MAY 8, 1961, to MAY 24, 1961, that (I) (~~saw~~) last saw the deceased alive on MAY 24, 1961, and that death occurred at 8:27A M, from the causes and on the date stated above.

22a. SIGNATURE: Edward A. Beeman — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: MAY 24, 1961
22c. PHYSICIAN'S NAME (Type): EDWARD A. BEEMAN
22d. ADDRESS: 10620 GEORGIA AVE. SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
23b. DATE THEREOF: 5/27/61
23c. NAME OF CEMETERY OR CREMATORY: Elks View Masonic Cem.
23d. LOCATION (City, town, or county) (State): Clarksburg, W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR: DATE MAY 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 [illegible] after death. Page 4 may be [illegible] by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

M

0019

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5798

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05785

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cabin John
d. STREET ADDRESS: 6914 Seven Locks Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

58

1

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Edward — Last: Hart

4. DATE OF DEATH: Month: May — Day: 31 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Col

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 27 1920

9. AGE (In years last birthday): 41 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Thomas Hart

14. MOTHER'S MAIDEN NAME: Mary Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Dorothy Hart (Wife) Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
(b): Myocardial hypertrophy — unknown
DUE TO
(c): Cor pulmonale — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

434.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Frank J. Brochart M.D.

EXAMINER'S NAME (Type) Frank J. Brochart

Address (Street, city, town, or county):

DATE SIGNED 5-31-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/5/61

22c. NAME OF CEMETERY OR CREMATORY: Arlington National.,

22d. LOCATION (City, town, or country) (State): Arlington, Va.

23. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR DATE JUN 7 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5799

CERTIFICATE OF DEATH

05786

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 1658-2
d. STREET ADDRESS: 6900 23rd. Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mr. James; Middle: Moore; Last: Hartley
4. DATE OF DEATH: Month: May; Day: 5; Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 12, 1881
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bank Clerk, Nat. Bk. of Wash,
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Hartley
14. MOTHER'S MAIDEN NAME: Emily Cook
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 577-22-1690
17. INFORMANT: Washington Sanitarium and Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO (b) Congestive heart failure — 5 yrs
DUE TO (c) Chronic pyelonephritis
Acute prostatitis
Carcinoma prostate

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/21, 1961, to 5/4, 1961, that (I) (we) last saw the deceased alive on 5/4, 1961, and that death occured at 5:05 A.M., from the causes and on the date stated above.

22a. SIGNATURE: H. Wayne Glickfield M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/5/61
22c. PHYSICIAN'S NAME (Type): H. WAYNE GLICKFIELD
22d. ADDRESS: 6826 Riggs Rd. Hyatts. Md.

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): burial
23b. DATE THEREOF: 5/9/61
23c. NAME OF CEMETERY OR CREMATORY: Nat. Mem. Park Cemetery
23d. LOCATION (City, town or county) (State): Falls Church, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co., ADDRESS: 2901 14th St. N.W. Wash, D C.
25a. REC'D BY REGISTRAR: DATE MAY 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5800

CERTIFICATE OF DEATH

05787

M

1. PLACE OF DEATH
e. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sant + Hospt.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 4870 Ft. Totten dr. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

47 x -3

3. NAME OF DECEASED (Type or print): First: Fern; Middle: Callie; Last: Harvey

4. DATE OF DEATH: Month: 5; Day: 31; Year: 1961

5. SEX: Fe.

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-24-1907

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWF.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY? Amer.

13. FATHER'S NAME: Spencer Abbott.

14. MOTHER'S MAIDEN NAME: Fern Prather

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT: Joseph C. Harvey, Husband. Address: Same # 2

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Diabetic coma — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO (b):
DUE TO (c): Diabetes mellitus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/30/61, 19..., to 5/31/61, 19..., that (I) (we) last saw the deceased alive on 5/31/61, 19..., and that death occured at 9:54 AM, from the causes and on the date stated above.

22a. SIGNATURE: A W Smith, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/31/61

22c. PHYSICIAN'S NAME (Type): A.W. SMITH

22d. ADDRESS: 13018 GEORGIA AVE W HEATON, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/3/61

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

23d. LOCATION (City, town or county) (State): Prince Georges County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: S H Hines Co

ADDRESS: 2901 14St NW

25a. REC'D BY REGISTRAR: DATE JUN 1 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5801

CERTIFICATE OF DEATH

05788

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
LENGTH OF STAY IN 1b: 11 days 3 hrs 35 min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: 35 S. Westland St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nettie Middle: A Last: Heffner
4. DATE OF DEATH: Month: May Day: 29 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/13/98
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank Nichols
14. MOTHER'S MAIDEN NAME: Sally Nichols
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: daughter Marie Thompson Address: 512 - N. Horst Ave Rockville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a): cerebral vascular accident — 30'

DUE TO (b): cerebral arteriosclerosis — unknown

DUE TO (c): generalized arteriosclerosis

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): diabetes mellitus & uremia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 1, 1953, to 5/29/, 1961, that (I) (we) last saw the deceased alive on 5/29/1961, and that death occured at 10:10 PM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/29/61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/1/61
23c. NAME OF CEMETERY OR CREMATORY: Forrest Oak
23d. LOCATION (City, town or county): Gaithersburg (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Constance C. Hilton ADDRESS: Barnesville Md.
25a. REC'D BY REGISTRAR DATE JUN 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5802

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G287 5/19/61 iwk

05789

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 14140 Great Oak Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: Edward; Last: Heidenreich
4. DATE OF DEATH: Month: May; Day: 13; Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1904 1-9-1904 57
9. AGE (In years last birthday): 57 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Vice Pres.
10b. KIND OF BUSINESS OR INDUSTRY: Fisher Scientific co
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Wm Heidenreich
14. MOTHER'S MAIDEN NAME: Eve Speider
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 167-05-5172
17. INFORMANT: Josephine Heidenreich - (wife) Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of previous heart attacks
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Bruschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-13-61
EXAMINER'S NAME (Type): FRANK J. Bruschart
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 16, 1961
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or country) (State): Montgomery County Maryland

23. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc. ADDRESS: 8434 Georgia Avenue Silver Spring, Maryland
Raymond A. Ziska
24a. REC'D BY REGISTRAR DATE: MAY 17 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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5803

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05790

M

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood, R.F.D. #1
c. LENGTH OF STAY IN 1b: 7 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ammons Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Highland, Md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Franklin Middle Last Holland
4. DATE OF DEATH: Month May Day 19 Year 19 61
5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 31, 1899
9. AGE (In years last birthday): 62 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Grafton Holland
14. MOTHER'S MAIDEN NAME: Elizebeth White
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Laura Wilson Address: Highland, Md (Sister)

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MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure.
DUE TO (b) C. V. A. — years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hypertension
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960, 19__, to 5/19, 1961, that (I) (we) last saw the deceased alive on 5/18 1961, and that death occurred at 4:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Luciano I. Leal M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Luciano I. Leal
22d. ADDRESS: Gaithersburg Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/23/61
23c. NAME OF CEMETERY OR CREMATORY: Hopkins Chapel Cem
23d. LOCATION (City, town, or county) (State): Highland, Md
24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR DATE MAY 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5804 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05791

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 4004 Hampdon St

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington 35
d. STREET ADDRESS: 4003 Hampdon St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard; Middle: ; Last: Hopkins
4. DATE OF DEATH: Month: May; Day: 23; Year: 19 61
5. SEX: male
6. COLOR OR RACE: col.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 20, 1900
9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Carrie Hopkins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Rose Nickens, Address: 4003 Hampden St., Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of previous heart desease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Brosohart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5/23/61
EXAMINER'S NAME (Type): Frank J. Brosohart
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/27/61
22c. NAME OF CEMETERY OR CREMATORY: Ash Memorial,
22d. LOCATION (City, town, or country) (State): Sandy Spring, Md.

23. FUNERAL DIRECTOR: Robert L. Sunde — ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR — DATE: JUN 7 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5805 05793

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
d. STREET ADDRESS 4626 Chestnut Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Thomas Middle Gregory Last Hutton
4. DATE OF DEATH Month May Day 9, Year 19 61
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH January 5, 1899
9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Social Analyst
10b. KIND OF BUSINESS OR INDUSTRY Social Security
11. BIRTHPLACE (State or foreign country) Scotland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Hutton
14. MOTHER'S MAIDEN NAME Isabella M. Wall
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unascertainable
17. INFORMANT The Medical Records Address The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

420.1

DUE TO (b) Acute myocardial infarction — days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Hypertensive & Arteriosclerotic heart disease — 15 + years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from May 9, 1961, to May 9, 1961, that ☒ (we) last saw the deceased alive on May 9, 1961 and that death occurred at 6:10AM from the causes and on the date stated above.

22a. SIGNATURE Harry R. Keiser M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED 5/9/61
22c. PHYSICIAN'S NAME (Type) Harry R. Keiser, M.D.
22d. ADDRESS National Institutes Of Health The Clinical Center, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
23b. DATE THEREOF 5-10-61
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory
23d. LOCATION (City, town, or county) (State) Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAY 11 '61
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5806 Item 166, Film G-266 5/9/61.cac 05794

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 68 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Whippany 67X-3
d. STREET ADDRESS: 130 Parsippany Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edward — Middle Joseph — Last Izykowicz
4. DATE OF DEATH: Month May — Day 2, — Year 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 25,1926
9. AGE (In years last birthday): 35 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George Izykowicz
14. MOTHER'S MAIDEN NAME: Anna Sharry
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Open heart surgery with total replacement of aortic valve — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b) Aortic valvular insufficiency — 4-5 months
DUE TO
(c) Subacute bacterial endocarditis and Rheumatic Heart disease — 20 years

430.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from February 23, 19 61 to May 2, 19 61 that (I) (we) last saw the deceased alive on May 2, 19 61, and that death occurred at 2:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James L. Talbert M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 5-2-61
22c. PHYSICIAN'S NAME (Type): James L. Talbert M.D.
22d. ADDRESS: The Clinical Center National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 5/3/61
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery
23d. LOCATION (City, town, or county) (State): Whippany, New Jersey
24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE MAY 4 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

M

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TO DEPARTMENT OF HEALTH: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5807

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05795

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium Hosp. Takoma Park

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 205 Dogwood Ave
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Novella Middle: Celestia Last: James
Novella Celestia James

4. DATE OF DEATH: Month 5 Day 30 Year 1961

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4-15-79
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: George W. Rison
14. MOTHER'S MAIDEN NAME: Alice V. Mattingly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None.
17. INFORMANT: Mrs Alice M Reamy — Address: Same Address — Daughter

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
Collapsed in bath room at home

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-30-61
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 6/1/61
22c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery
22d. LOCATION (City, town, or country) (State): Washington, D.C.

23. FUNERAL DIRECTOR: The S.H. Hines Co.
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR: DATE JUN 1 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Hines

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5803

CERTIFICATE OF DEATH

05796

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 54 Chevy Chase 15
d. STREET ADDRESS: 7104 Beechwood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nora — Middle: T — Last: Jarvis

4. DATE OF DEATH: Month: May — Day: 15 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 3/17/83

9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Waterville, Ireland

12. CITIZEN OF WHAT COUNTRY?: U.S.A 50 yrs.

13. FATHER'S NAME: John Oulihan

14. MOTHER'S MAIDEN NAME: Joanna Foley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.: None

17. INFORMANT: W.F. Jarvis (son) Address: Bloomfield Hills, Mich

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: + days
DUE TO (b): Arteriosclerosis — + years
DUE TO (c):

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pulmonary Tuberculosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 5, 1961, to May 15, 1961, that (I) ~~(we)~~ last saw the deceased alive on May 14, 1961, and that death occured at 6 40 AM, from the causes and on the date stated above.

22a. SIGNATURE: J. R. Raedy M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-15-61

22c. PHYSICIAN'S NAME (Type): J. R. Raedy

22d. ADDRESS: 3701 Leland ST Chevy Chase Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6-17-61

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 19 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

Burial: 6-17-61 Mt. Olivet Cemetery Washington, D. C.

ROBERT A. HUMPHREY Bethesda, Md.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5809

CERTIFICATE OF DEATH

05797

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 8 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: LeDeau Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: FAIRFAX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Falls Church
d. STREET ADDRESS: 906 Crutchfield Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertha Middle: N. Last: Johnson

4. DATE OF DEATH: Month: May Day: 11 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 11, 1877
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown Anderson
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Carl F. Johnson Address: 906 Crutchfield Street Falls Church, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO
(b) Lobar Pneumonia, Left — 5 Days
DUE TO
(c) Hemiparesis, left

352X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 1961, to May 11 1961, that (I) (we) last saw the deceased alive on May 11 1961, and that death occurred at 9 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert T. Thibadeau M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 11-61
22c. PHYSICIAN'S NAME (Type): Robert T. Thibadeau, M.D.
22d. ADDRESS: 10609 Concord Street Kensington, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Transit-burial
23b. DATE THEREOF: 5/12/61-5/14/61
23c. NAME OF CEMETERY OR CREMATORY: Pittsfield Cemetery
23d. LOCATION (City, town, or county) (State): Pittsfield, Massachusets

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zicka
ADDRESS: Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Maryland.
25a. REC'D BY REGISTRAR DATE: MAY 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Wheaton Nursing Home

05798

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wheaton Nursing Home, 2102 Hildarose Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 SILVER SPRING
d. STREET ADDRESS: 2102 HILDAROSE DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First HARRY Middle ALBERT Last JOHNSON

4. DATE OF DEATH: Month ~~APRIL~~ S.T.K. Day ~~5th~~ MAY 1 Year ~~1890~~ 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APRIL 5, 1890
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Claims Adjuster
10b. KIND OF BUSINESS OR INDUSTRY: Capital Transit
11. BIRTHPLACE (County & State, or foreign country): St Louis Mo
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HENRY C JOHNSON
14. MOTHER'S MAIDEN NAME: VIRGINIA CORR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: KATHERINE F JOHNSON — Address: 2102 Hildarose Dr.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b) Bronchogenic carcinoma — 6 months
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 162.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from August, 1957 to May 1, 1961, that (I) ~~(we)~~ last saw the deceased alive on May 1, 1961, and that death occured at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Lenoch T. Kimble M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 1, 1961
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 927 Pershing Drive, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-4-61
23c. NAME OF CEMETERY OR CREMATORY: Gilbelandering Church
23d. LOCATION (City, town or county) (State): Fairview Va

24 FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home — ADDRESS: 4812 Georgia Ave
25a. REC'D BY REGISTRAR DATE MAY 5 '61
25b. REGISTRAR'S SIGNATURE: Cathrine S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5811 Items 7 & 12 Film G286 5/8/61 iwk 65799

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Resmor Hospital Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: 1830 R. St. N.W. — COUNTY: 47X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C.
d. STREET ADDRESS: 5721 Grosvenor Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Samuel, Middle A., Last Johnson
4. DATE OF DEATH: Month May, Day 2, Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 22 1870
9. AGE (In years lost birthday): 90 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engraver
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Frederick Johanesen
14. MOTHER'S MAIDEN NAME: UNKNOWN
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Astrid J. Highfield, Address 1830 R St N.W. Wash. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	HYPOTENSION + RESPIRATORY ARREST	3 MINS.
DUE TO (b)	UREMIA	6 MONTHS.
DUE TO (c)	CHRONIC PYELONEPHRITIS	12 YEARS.

600.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PROSTATIC CARCINOMA; GENERALIZED ARTERIOSCLEROSIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from SEPT. 14 1956 to MAY 2 1961, that (I) (we) last saw the deceased alive on APRIL 30, 1961, and that death occurred at 3 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Joseph D. Connor M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 2, 1961
22c. PHYSICIAN'S NAME (Type): JOSEPH D. CONNOR, M.D.
22d. ADDRESS: 9420 OLD GEORGETOWN RD BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/3/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town, or county) (State): Pr. Geo. Co. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chamberlin Co. — ADDRESS: 1400 Chapin St. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR: DATE MAY 3 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5812

CERTIFICATE OF DEATH

45890

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. Sam & Hospital

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10033 Dallas Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna; Middle: E.; Last: Johnston

4. DATE OF DEATH: Month: 5; Day: 19; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: May 26, 1882

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown Ireland

14. MOTHER'S MAIDEN NAME: Unknown Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give were or dates of service): No

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Mrs. Harold D. Breckwell
Address: 10,033 Dallas Ave, Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO (b): Hypertension — 10 yr
DUE TO (c):

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 15, 1955 to May 19, 1961, that (I) (we) last saw the deceased alive on May 11, 1961, and that death occured at 10:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Arthur H Lewis M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ARTHUR H. LEWIS

22d. ADDRESS: 1714 R I Ave NW Wash, DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 23, 1961

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

23d. LOCATION (City, town or county) (State): Montgomery County, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A Zska
ADDRESS: Warner E. Pumphrey, Inc. 8434 Georgia Ave, Silver Spring, Md.

25a. REC'D BY REGISTRAR DATE MAY 26 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death, [illegible] may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5813 **CERTIFICATE OF DEATH** 05801

1 M 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

075

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, 23
d. STREET ADDRESS: 25 E. Wayne Avenue, Apt. 305
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Jones

4. DATE OF DEATH: Month: May — Day: 18, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 18, 1961

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 3 — Min.: 48

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: America

13. FATHER'S NAME: George Chalmers Jones

14. MOTHER'S MAIDEN NAME: Molina Ellen Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give were or dates of service): no

16. SOCIAL SECURITY NO.: no

17. INFORMANT: father — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hyaline disease + atelectasis
762.0
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occured at.....M, from the causes and on the date stated above.

22a. SIGNATURE: Herbert J. Jacobs M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-18-61

22c. PHYSICIAN'S NAME (Type): Herbert J. Jacobs, M. D.

22d. ADDRESS: 10620 Georgia Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 5-18-61

23c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hospital,

23d. LOCATION (City, town or county) (State): Takoma Park, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Robert Hare, M. D.

ADDRESS: Washington Sanitarium and Hospital

25a. REC'D BY REGISTRAR DATE: MAY 23 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

2175201XU2

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5814 — 05892

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN this place: 1 day 6 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cabin John
d. STREET ADDRESS: 6425-78 street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: W. — Last: Jones

4. DATE OF DEATH: Month: May — Day: 24 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 10/4/77
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stone Mason
10b. KIND OF BUSINESS OR INDUSTRY: Private
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel Jones.
14. MOTHER'S MAIDEN NAME: Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 217-03-3635
17. INFORMANT: Mrs. Estelle Jones / Same as above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 Days
DUE TO (b): Cerebral Thrombosis — 3 Days
DUE TO (c): Cerebral Arteriosclerosis — Unknown

332X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/23, 1961, to 5/24, 1961, that (I) (we) last saw the deceased alive on 5/23 1961, and that death occured at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5/27/61
22c. PHYSICIAN'S NAME (Type): A.W. DANISH
22d. ADDRESS: 927 Pershing Dr. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/27/61
23c. NAME OF CEMETERY OR CREMATORY: Reformed Church Cem.
23d. LOCATION (City, town or county) (State): Shephardstown, W. Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: MAY 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5815 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 06943

Item 9 Film G288 6/14/61 iwk

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 124 Johnson Dr.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 124 Johnson Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle:; Last: Jones
4. DATE OF DEATH: Month: May; Day: 31; Year: 19 61
5. SEX: female
6. COLOR OR RACE: col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 20, 1883
9. AGE (In years last birthday): 76/77 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Emily Harriday, Address: Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: May 31 1961
EXAMINER'S NAME (Type): Frank J. Broschart
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 27, 1961
22c. NAME OF CEMETERY OR CREMATORY: Haiti.,
22d. LOCATION (City, town, or country) (State): Rockville, Md.

23. FUNERAL DIRECTOR: Robert L. Snowden ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE JUN 12 '61
24b. REGISTRAR'S SIGNATURE: Cindus L. Kraus

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5816

Reg. Dist. No. 05803

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Sandy Spring~~ Olney
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-- Mt. Airy
d. STREET ADDRESS: R. D. 2 06X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SALEEM Middle SOLOMON Last KABALAN

4. DATE OF DEATH: Month May Day 10, Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: July 12, 1887
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor--Sewer & Water
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Aramoun, Lebanon
12. CITIZEN OF WHAT COUNTRY? Naturalized

13. FATHER'S NAME: Solomon H. Kabalan
14. MOTHER'S MAIDEN NAME: Muhsny Laytoun

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---------- (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-10-9773
INFORMANT: Mr. Said S. Kabalan, Address 2623 Hampton Rd. Rocky River 16, Ohio

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary occlusion, recurrent — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
420.1
DUE TO
(b) Arteriosclerosis, generalized — years
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic congestive failure; diabetes mellitus, mild

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 4/26/61, 19___, to 5/10/61, 19___, that I last saw the deceased alive on 5/10/61, 19___, and that death occurred at 8:25P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: G. Meadors M.D.
ADDRESS (Street, city or town, state): Main Street
DATE SIGNED:
PHYSICIAN'S NAME (Type): G.F. Meadors, M.D. Damascus, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 15, 1961
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
22d. LOCATION (City, town, or county) (State): North Olmsted, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: C. M. Waltz, ADDRESS: Winfield, Maryland
24a. REC'D BY REGISTRAR DATE MAY 15 '61
24b. REGISTRAR'S SIGNATURE: Clifford S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5817

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05804

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 1/2 hr.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Lakewood Country Club

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: DC
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5415 Conn. Ave, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Donald Middle: C. Last: Keith
4. DATE OF DEATH: Month: May Day: 16 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-20-05
9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Vitro Corp.
10b. KIND OF BUSINESS OR INDUSTRY: Vitro Corp
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Lincoln Keith
14. MOTHER'S MAIDEN NAME: Cora Cain
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Yes Unknown
17. INFORMANT: Alice Keith-sister-3338 Address: Washington, D. C. N. W 16th Street, N.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: Died suddenly while playing golf.
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 5-16-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 5/17/61
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or country) (State): Suitland, Maryland
23. FUNERAL DIRECTOR: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE MAY 19 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5818 **CERTIFICATE OF DEATH** 05805

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 31 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 4211 Bradley Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: Henry; Last: Kelley
4. DATE OF DEATH: Month: May; Day: 29; Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/12/74
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Custodian Am. Security Bank
11. BIRTHPLACE (County & State, or foreign country): S. Coventry, Conn.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Patrick ~~XXXX~~ Kelley
14. MOTHER'S MAIDEN NAME: Mary Brannigan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-01-5209A
17. INFORMANT: Mrs. Esther Cantrell (Daughter) — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism
465X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Perforated Duodenal Ulcer

19. WAS AUTOPSY (PERFORMED)? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from September, 1955, to May 29, 1961, that (I) ~~(we)~~ last saw the deceased alive on May 28 1961, and that death occured at 7 A.M, from the causes and on the date stated above.

22a. SIGNATURE: J. Blaine Fitzgerald M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-29-61.
22c. PHYSICIAN'S NAME (Type): J. Blaine Fitzgerald
22d. ADDRESS: 8218 Wisconsin Avenue - Bethesda

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6/7/61
23c. NAME OF CEMETERY OR CREMATORY: Mount St. Benedict Cemetery
23d. LOCATION (City, town or county) (State): Hartford, Conn.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska
ADDRESS: Werner E. Pumphrey, Inc. 8434 Georgia Ave. SS Md.
25a. REC'D BY REGISTRAR DATE JUN 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5819 — 05806

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: 4 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 3304 Winnett Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 3304 Winnett Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rodhana — Middle: Woinder — Last: Kenner
4. DATE OF DEATH: Month: May — Day: 30 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-19-1900
9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Executive
10b. KIND OF BUSINESS OR INDUSTRY: Little Tavern
11. BIRTHPLACE (State or foreign country): DC
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Harry W. Kenner
14. MOTHER'S MAIDEN NAME: Ada Crandall
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Betty Kenner (wife) — Address: Stew 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
420.1
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): History of previous heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 5-30-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 6/1/61
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or country) (State): Suitland, Maryland
23. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE JUN 2 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Item 20 Film 288
5-31-61 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5820 — 05807

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3100 Connecticut Ave., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47 x-2

3. NAME OF DECEASED (Type or print): First: Adele — Middle: Cooke — Last: KINGSTON
4. DATE OF DEATH: Month: May — Day: 19 — Year: 19 61
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-25-79
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles W. COOKE
14. MOTHER'S MAIDEN NAME: Josephine ROGERS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (H) Arthur Kingston, same as #2 above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pulmonary Embolism
DUE TO (b) postoperative open reduction left Femur fracture
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 904.0

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home
20c. TIME OF INJURY: Hour 6 p.m. — Month, Day, Year: 5-11 1961
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) Washington (County) D.C. (State)

21. I certify that ☒ (this hospital) attended the deceased from May 13 1961, to May 19, 19 61 that (☒ (we) last saw the deceased alive on May 19 19 61, and that death occured at 4:55AM M, from the causes and on the date stated above.

22a. SIGNATURE: GB Townsend M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-19-61
22c. PHYSICIAN'S NAME (Type): G. B. TOWNSEND, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/23/1961
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county): Arlington (State) Virginia
24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's & Sons
ADDRESS: WashDC
Jos. Gawler's & Sons Funeral Home, 1756 Pa.Ave.NW
25a. REC'D BY REGISTRAR DATE: MAY 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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Monogamy District of Columbia

Pathenda (Rural) 6 days Washington

U. S. Naval Hospital 3100 Connecticut Ave., N.W. x

Male Cooke KINGSLEY May 19 61

Female Caucasian 9-29-79 Bl

Husband - - - - - Maryland UBA

Charles W. COOKE Josephine K COKE

No None (H) Arlene Kingston, same as #2 above

x

x

May 19 61 May 19 61 May 19 61 x

4:25AM

x 3-19-61

G. D. TOWNSEND, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

Burial 3/23/1961 Arlington National Cemetery Arlington Virginia

Joe. Gawler's & Sons Funeral Home, 1750 Pa.Ave.NW

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5821

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 238 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington 38
d. STREET ADDRESS: 11908 Coronada Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Trudy; Middle: Lynn; Last: Kruis
4. DATE OF DEATH: Month: May; Day: 17; Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 21, 1951
9. AGE (In years last birthday): 9 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Kruis
14. MOTHER'S MAIDEN NAME: Mae Van Zwol

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ? Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b) Acute lymphocytic leukemia — 8 months
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1 204.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from September 21, 1960 to May 17, 1961, that (I) (we) last saw the deceased alive on May 17 1961, and that death occurred at 11 P.M. from the causes and on the date stated above.

22a. SIGNATURE: June B Block M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5/18/61
22c. PHYSICIAN'S NAME (Type): JEROME B. BLOCK, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 22, 1961
23c. NAME OF CEMETERY OR CREMATORY: Zuttphen Cemetery
23d. LOCATION (City, town, or county) (State): Hudsonville, Mich.

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. — ADDRESS: Riverdale Md.
25a. REC'D BY REGISTRAR DATE: MAY 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

VR A1S (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5822 Item 6 Film 0287 5/22/61 mh 65809

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 27 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 09 Rockville
d. STREET ADDRESS: 616 Douglas Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ola Middle: ✓ Last: Starr
4. DATE OF DEATH: Month: May Day: 12 Year: 1961
5. SEX: female
6. COLOR OR RACE: colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: April 10, 1889
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months —; Days ?; IF UNDER 24 HRS.: Hours ?; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Montgomery Co.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Clem Paul Martin
14. MOTHER'S MAIDEN NAME: Clara Hawkins
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Evelyn Daphney Address: 616 Douglas, Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) cerebral accident — 6 days
331X
DUE TO (b) Cerebral Arteriosclerosis & dementia — 6 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Feb-27-1955 to May-12-1961, that (I) (we) last saw the deceased alive on May-11-1961, and that death occurred at 9:20 A.M., from the causes and on the date stated above.

22a. SIGNATURE: William C. Miller M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): WILLIAM C. MILLER
22d. ADDRESS: 7 Brooke Ave., Gaithersburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/16/61
23c. NAME OF CEMETERY OR CREMATORY: Lincoln Park.
23d. LOCATION (City, town, or county) (State): Rockville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Sunde
ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR DATE: MAY 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Fraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5823 05810

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1. PLACE OF DEATH a. COUNTY: Montg. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg ~~Montg~~
c. LENGTH OF STAY IN 1b: 21yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Asbury Methodist Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: West Virginia b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darkesville
d. STREET ADDRESS:
• IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Delilah Middle: May Last: Legg
4. DATE OF DEATH: Month: May Day: 11 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 5, 1870
9. AGE (In years last birthday): 90 yrs. IF UNDER 1 YEAR: Months 6 Days 6 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hampshire Co., West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Samuel W. Anderson
14. MOTHER'S MAIDEN NAME: Sarah Elizabeth Kibler
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Asbury Methodist Home Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: years

420.0

DUE TO (b) Arteriosclerotic Heart Disease — years

DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-20 1960, to 5-11 1961, that (I) (~~was~~) last saw the deceased alive on 5-11 1961, and that death occurred at 2:00 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James W. Egan M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-11-61
22c. PHYSICIAN'S NAME (Type): James W. Egan
22d. ADDRESS: 7720 Wisconsin Ave Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-13-61
23c. NAME OF CEMETERY OR CREMATORY: Timber Ridge
23d. LOCATION (City, town, or county) (State): (Near) Gore. W. Va

24. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner. ADDRESS: Gaithersburg. Md,
25a. REC'D BY REGISTRAR DATE MAY 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5824 Item 2 Film G287 5/22/61 mb 05811

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CARROLL HALL (10231-CARROLL PLACE)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON Brooklyn
d. STREET ADDRESS: 1922 Bill Carroll Place 80 Winthrop St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IDA Middle: MARIAN Last: LLOYD
4. DATE OF DEATH: Month: MAY Day: 10 Year: 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: DEC. 27, 1870
9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: — — —
11. BIRTHPLACE (County & State, or foreign country): ENGLAND.
12. CITIZEN OF WHAT COUNTRY? GREAT BRITAIN.
13. FATHER'S NAME: WILLIAM LINNELL
14. MOTHER'S MAIDEN NAME: ELIZA GELL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 14 DAYS
DUE TO (b) GENERALIZED ARTERIOSCLEROSIS — —
DUE TO (c) ESSENTIAL HYPERTENSION — —

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): SENILITY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from JULY 21, 1957 to MAY 10, 1961, that (I) (~~we~~) last saw the deceased alive on MAY 10 1961, and that death occured at 9 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Henryan Lowden M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-10-61
22c. PHYSICIAN'S NAME (Type): HENRY M. LOWDEN
22d. ADDRESS: 3296 Norman Dr. Chevy Chase, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 5-12-1961
23c. NAME OF CEMETERY OR CREMATORY: ROCK CREEK CEMETERY
23d. LOCATION (City, town or county) (State): WASHINGTON, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Sons, Inc.
ADDRESS: 1756 - Pa. Ave. N.W.
25a. REC'D BY REGISTRAR: DATE MAY 12 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5825 — 05812

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8710 Plymouth
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert — Middle: Glenn — Last: Lloyd

4. DATE OF DEATH: Month: May — Day: 7 — Year: 1961

5. SEX: M
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-11-15
9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Highway Insp., D.C. Govt
10b. KIND OF BUSINESS OR INDUSTRY: D.C. Gov't
11. BIRTHPLACE (County & State, or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Lloyd
14. MOTHER'S MAIDEN NAME: Ruth Fetters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WW2 Army
16. SOCIAL SECURITY NO.:
17. INFORMANT: Kathryn Lloyd — Address: As deceased

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Inanition — INTERVAL BETWEEN ONSET AND DEATH: 12 months
581.0
DUE TO (b): Abdominal Ascites — 15 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Cirrhosis of Liver — 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. ~~DESCRIBE~~ HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from June, 1960, to 5-6-1961, that (I) (~~we~~) last saw the deceased alive on 5-6-1961, and that death occured at 5:25 A.M, from the causes and on the date stated above.

22a. SIGNATURE: N. C. Shoemaker M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/7/61
22c. PHYSICIAN'S NAME (Type): N. C. Shoemaker
22d. ADDRESS: 8005 Woodbury Dr. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Transit-Burial 5/7-5/10/61
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l. Cemetery, Arlington Co., Va. via McKee sport,
23d. LOCATION (City, town or county) (State): (Pa.) Silver Spring, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska — WARNER E. PUMPHREY, INC.
ADDRESS: SILVER SPRING, MD.
25a. REC'D BY REGISTRAR: MAY 12 '61 — DATE
25b. REGISTRAR'S SIGNATURE: Arline S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5826

CERTIFICATE OF DEATH

05813

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: Nine years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10,033 Renfrew Rd. Silver Spring, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring Md.
d. STREET ADDRESS: 10,033 Renfrew Rd. Silver Spring
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

30

3. NAME OF DECEASED (Type or print): First MARY Middle HELEN Last MANZI

4. DATE OF DEATH: Month 5 Day 18 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/20/14
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Mohawk, N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mr. John Bell Springfield, Mass
14. MOTHER'S MAIDEN NAME: Margaret Keough New York, N.Y.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 081-03-6973
17. INFORMANT: Mr. A. Robert Manzi 10,033 Renfrew Rd. Silver Address Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC INSUFFICIENCY — INTERVAL BETWEEN ONSET AND DEATH 4 wks
581.0
DUE TO (b) HEPATIC CIRRHOSIS — 6 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from March 1961 to May 1961, that (I) (we) last saw the deceased alive on 5-15 1961, and that death occurred at 11:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Bernard L. Fitzgerald M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Bernard L. Fitzgerald
22d. ADDRESS: 217 UNIVERSITY BLVD E. S.S. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 5/21/61
23c. NAME OF CEMETERY OR CREMATORY: St. Agnes Cemetery
23d. LOCATION (City, town, or county) (State): Onandaga County Syracuse N.Y.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Fiska
ADDRESS: Silver Spring
Warner E. Pumphrey, Inc. 8434 Georgia Ave., Md.
25a. REC'D BY REGISTRAR DATE: MAY 23 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5827 — 05814

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park Md.
c. LENGTH OF STAY IN 1b: 55 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash. Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 9628 Old Spring Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: ~~Lee~~ COLE — Last: Marsteller
4. DATE OF DEATH: Month: May — Day: 24 — Year: 1961
5. SEX: F
6. COLOR OR RACE: ~~Amer.~~ WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-29-02
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George R. Cole
14. MOTHER'S MAIDEN NAME: Minnie Dorsey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Unknown — (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Chart - Wash. San. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Breast c̄ Metastases — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.
170X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pleural Empyema
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
2Dd. INJURY OCCURRED: While at work ☐ Not While at work ☐
2Da. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-7, 1961, to 5-24, 1961, that (I) (we) last saw the deceased alive on 5-24 1961, and that death occured at 10:25 A.M., from the causes and on the date stated above.

22a. SIGNATURE: James W. Egan M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/24/61
22c. PHYSICIAN'S NAME (Type): James W. Egan
22d. ADDRESS: 7720 Wisconsin Ave. - Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/27/61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county) (State): Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zisch
ADDRESS: Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Md.
25a. REC'D BY REGISTRAR: DATE MAY 31 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5828

CERTIFICATE OF DEATH

Reg. Dist. No. 05815

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3201 Pickwick Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 52 Chevy Chase
d. STREET ADDRESS: 3201 Pickwick Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Eugene — Middle: J. — Last: Matchett
4. DATE OF DEATH: Month: May — Day: 3 — Year: 19 61

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/11/99
9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Administrative officer
10b. KIND OF BUSINESS OR INDUSTRY: Dept. of Justice
11. BIRTHPLACE (State or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas L. Matchett
14. MOTHER'S MAIDEN NAME: Harriet E. Ramler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Eugene J. Matchett, Jr. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma (Anaplastic) Lung — INTERVAL BETWEEN ONSET AND DEATH: 3½ mo
163 X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 15, 1959, to May 3, 1961, that I last saw the deceased alive on May 3, 1961, and that death occurred at 5:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Arthur H Lewis M.D. — ADDRESS (Street, city or town, state): 1714 R I Ave NW — DATE SIGNED: 5/3/61
PHYSICIAN'S NAME (Type): ARTHUR H. LEWIS — Washington DC

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 5/6/61
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Montgomery County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. — ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR: DATE MAY 8 '61
24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5825 — 05816

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 804 Van Buren Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or Print): First: Samena — Middle: — Last: Maxwell
4. DATE OF DEATH: Month: May — Day: 27 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 18, 1881
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Art teacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James B. Maxwell
14. MOTHER'S MAIDEN NAME: Isabella Johnson.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.:
17. INFORMANT: Sister + Dr. K. Chapman — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lower bowel with metastasis — INTERVAL BETWEEN ONSET AND DEATH: ?

153.8

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Was a Christian Scientist + had no family physician.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 5-28-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 6/1/61
22c. NAME OF ~~CEMETERY~~ OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town, or country): Pr. Geo. Co. — (State): Md.
23. FUNERAL DIRECTOR: W. W. Chambers Co. — ADDRESS: 1400 Chapin St.
24a. REC'D BY REGISTRAR DATE: MAY 31 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Graves

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5830

CERTIFICATE OF DEATH

05817

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1 M I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 35 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d. STREET ADDRESS: 408 E. Glendale Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Allen — Middle: Ross — Last: MC DERMOTT
4. DATE OF DEATH: Month: May — Day: 1 — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-20-34
9. AGE (In years last birthday): 26 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electronic Technician
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Ross W. MC DERMOTT
14. MOTHER'S MAIDEN NAME: Mamie E. KROMLING
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): 1955 to 1957
16. SOCIAL SECURITY NO.: 230-42-0365
17. INFORMANT: (W) Mrs. Patricia A. McDermott, same as #2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

201X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (X) (this hospital) attended the deceased from March 27 1961 to May 1, 19 61 that (X) (we) last saw the deceased alive on May 1 19 61, and that death occured at 6:15AM M, from the causes and on the date stated above.

22a. SIGNATURE: R. G. Muth M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 5-1-61
22c. PHYSICIAN'S NAME (Type): R. G. MUTH, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-4-61
23c. NAME OF CEMETERY OR CREMATORY: National Memorial Park
23d. LOCATION (City, town or county) (State): Falls Church Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Cunningham Funeral Home, Cameron & Alfred Sts. — ADDRESS: Alexandria, Va.
25a. REC'D BY REGISTRAR — DATE: MAY 3 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5831 — 65818

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 25 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12710 Layhill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Oscar — Middle: Paul — Last: McKay

4. DATE OF DEATH: Month: May — Day: 20, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: March 9, 1891

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurseryman
10b. KIND OF BUSINESS OR INDUSTRY: Nursery
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: William McKay — Scotland
14. MOTHER'S MAIDEN NAME: Elizabeth Lang — Washington D.C.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW #1
16. SOCIAL SECURITY NO.: 214-03-9362
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1954 to May 20 1961, that (I) (we) last saw the deceased alive on May 20 1961, and that death occurred at 2:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: A. D. Bonifant M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/20/61
22c. PHYSICIAN'S NAME (Type): Alfred D. Bonifant, MD
22d. ADDRESS: Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/24/61
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cemetery
23d. LOCATION (City, town, or county) (State): Montgomery County, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska
ADDRESS: Warner E. Pumphrey, Inc. 8434 Georgia Avenue, Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: MAY 26 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5832 05814

1 M I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 814 E. Street, N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

051

3. NAME OF DECEASED (Type or print): First: Elnora; Middle: Marie; Last: MC LAUGHLIN

4. DATE OF DEATH: Month: May; Day: 12; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 18 June 1883

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Asbury

14. MOTHER'S MAIDEN NAME: Hoffman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: James Edward MC LAUGHLIN — Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO (b) Arteriosclerotic Heart Disease — 5 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.00

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that ☒ (this hospital) attended the deceased from 8 May, 19 61 to 12 May, 19 61 that ☐ (we) last saw the deceased alive on 12 May 19 61, and that death occured at 11 Am from the causes and on the date stated above.

22a. SIGNATURE: J.M. Young M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): J.M. YOUNG LT MC USN

22d. ADDRESS: U.S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-16-61

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: J. W. Lee & Sons — ADDRESS: Lee Funeral Home 4th & Massachusetts Ave. W.D.C.

25e. REC'D BY REGISTRAR — DATE MAY 17 '61

25b. REGISTRAR'S SIGNATURE: Anthony S. Kiernan

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5833 — 05820

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 34yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 11409 Maple View Dr

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 11409 Maple View Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nettie — Middle: Naomi — Last: McNall
4. DATE OF DEATH: Month: May — Day: 8 — Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 25 1894
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Daniel Cunningham
14. MOTHER'S MAIDEN NAME: ~~Nick~~ Naomi Dick
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr William F McNall, Sr — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 36 hours
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 1959 to May 7, 1961, that (I) (we) last saw the deceased alive on May 7 1961, and that death occurred at 12:15 AM from the causes and on the date stated above.

22a. SIGNATURE: John Lawrence Avery M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): John Lawrence AVERY
22d. ADDRESS: 10110 Georgia Ave., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): XXXXX
23b. DATE THEREOF: 5/11/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn
23d. LOCATION (City, town, or county) (State): Rockville, Montgomery, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Riska. — Warner E. Humphrey, Inc. — ADDRESS: 8434 Georgia Ave, Silver Spring, Md.
25a. REC'D BY REGISTRAR — DATE: MAY 12 '61
25b. REGISTRAR'S SIGNATURE: Arthur B. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5834 — 05821

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): WASH. SAN.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 34
d. STREET ADDRESS: 4106 Havard st 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Abraham — Middle: — Last: Meltzer

4. DATE OF DEATH: Month: 5 — Day: 27 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 10-23-94

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Photographer - retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Roumania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Mr. ~~Jerome~~ Isaac Meltzer

14. MOTHER'S MAIDEN NAME: Clara Gottfried

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): National guards W.W.I

16. SOCIAL SECURITY NO.: 093-09-5403

17. INFORMANT: Son (Jerome J. Meltzer) + old Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): anemia — INTERVAL BETWEEN ONSET AND DEATH: 2 months.
DUE TO (b): arteriosclerosis — 2 years.
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

442

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension and arteriosclerotic heart disease.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 1961 to May 27, 1961, that (I) ~~(we)~~ last saw the deceased alive on May 27 1961, and that death occured at 5 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Lemuel T. Kimble M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 27 May 61.

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: 927 Pershing Drive, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5/29/1961

23c. NAME OF CEMETERY OR CREMATORY: GEO. WASH. CEM.

23d. LOCATION (City, town or county) (State): HYATTSVILLE, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: Geddings Funeral Home 4-2117-9-2 Md

ADDRESS:

25a. REC'D BY REGISTRAR DATE MAY 31 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

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1

5835

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05822

M

050

I

2

1

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 39 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: District of Columbia b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3636 - 16th Street, N.W. Apt. A-815
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X3

3. NAME OF DECEASED (Type or print): First: Irvin; Middle: Fletcher; Last: Meyer

4. DATE OF DEATH: Month: May; Day: 21; Year: 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 3, 1919
9. AGE (In years last birthday): 41 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Actuary, Internal
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Revenue Emanuel M. Meyer
14. MOTHER'S MAIDEN NAME: Julia Holzberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII
16. SOCIAL SECURITY NO.: Unascertainable
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 Hours

204.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Acute Myelogenous Leukemia — 7 Months

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 12, 19 61, to May 21, 19 61, that (I) (we) last saw the deceased alive on May 21, 19 61, and that death occurred at 9:30 AM from the causes and on the date stated above.

22a. SIGNATURE: Vincent H. Bono Jr. M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-21-61
22c. PHYSICIAN'S NAME (Type): Vincent H. Bono Jr. M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 5-23-1961
23c. NAME OF CEMETERY OR CREMATORY: Judo Toroah Cemetery
23d. LOCATION (City, town, or county) (State): Cincinnati, Ohio

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawlers Sons. Inc. ADDRESS: 1756 Pa. Ave. NW. Wash. 6, D.C.
25a. REC'D BY REGISTRAR DATE MAY 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5836 **CERTIFICATE OF DEATH** 05823

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 87 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. Naval Hospital, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5615 McKinley Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis; Middle: Gerard; Last: MILLER

4. DATE OF DEATH: Month: May; Day: 27; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2 August 1896

9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Marine Corps

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - - - - -

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry J. Miller

14. MOTHER'S MAIDEN NAME: Martha Upton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: - - - - -

17. INFORMANT: (D) Miss Carol Miller Address: same as # 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic carcinoma, lung, with metastasis — INTERVAL BETWEEN ONSET AND DEATH: 8 mos.
162.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ☒ (this hospital) attended the deceased from 3-1, 1961 to 5-27, 1961, that (I) ☒ (we) last saw the deceased alive on 5-27 1961, and that death occured 3:55 AM, from the causes and on the date stated above.

22a. SIGNATURE: F. H. O'Connell M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 27 May 1961

22c. PHYSICIAN'S NAME (Type): F. H. O'CONNELL, LCDR, MC USN

22d. ADDRESS: U.S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-31-61

23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: R.A. Pumphrey

ADDRESS: 1557 Wisconsin Avenue, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE MAY 31 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Montgomery Maryland Montgomery

Bethesda (Rural) By date Bethesda

U.S. Naval Hospital, Bethesda, Maryland 9013 Wisconsin Street x

Francis Gerard MILLER May 27 01

Male Caucasian x 2 August 1890 04

U.S. Marine Corps - - - - - - - - - Washington, D.C. USA

Henry J. Miller Marine Uptom

Yes WW II - - - - - (D) Miles Gerard Miller name as # 2 above

Bronchogenic carcinoma, lung, with metastasis 8 mos.

x

x 27 May 1951

E. H. O'CONNELL, LCDR, MC USN U.S. Naval Hospital, Bethesda, Maryland

Burial 3-27-51 Arlington National Cemetery Arlington, Virginia

R.H. Humphrey 9700 Wisconsin Avenue
Bethesda, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5837

CERTIFICATE OF DEATH

05824

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 20 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 519 Beall Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard — Middle: Wagonen — Last: MINDTE
4. DATE OF DEATH: Month: May — Day: 16 — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-15-04
9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (County & State, or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Carl MINDTE
14. MOTHER'S MAIDEN NAME: Lola FERN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWII-Korean
16. SOCIAL SECURITY NO.: 553-16-2519
17. INFORMANT: (S) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarct, posterior septal
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Calcific aortic stenosis; rt. upper lobe pneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (☒ (this hospital) attended the deceased from April 26, 19 61 to May 16, 19 61 that (☒ (we) last saw the deceased alive on May 16 19 61, and that death occured at 8:50 AM, from the causes and on the date stated above.

22a. SIGNATURE: Kenneth V. Harshman M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-16-61
22c. PHYSICIAN'S NAME (Type): Kenneth V. HARSHMAN, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-19-61
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county): Arlington (State): Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler
ADDRESS: Tyson Wheeler Funeral Home, Rockville, Md.
25a. REC'D BY REGISTRAR DATE MAY 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Montgomery Maryland Montgomery

Bethesda (Naval) 20 days Rockville

U. S. Naval Hospital 9th Bell Avenue

Richard Hagoman MINOR May 16 61

Male Chaplain x 10-15-04 56

Officer U. S. Navy Illinois USA

Carl LUNDTE Lois FRAN

Yes WALL-Aorsen 353-16-2919 (S)

Acute syncopital infarct, posterior septal heart

Calculus aortic stenosis; rt. upper lobe pneumonia x

x

May 16 61 April 20 6:30AM 61 May 16 61 x

x 5-16-61

Kenneth V. HARDIMAN, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

Burial 5-19-61 Arlington National Arlington Virginia

Ivson Wheeler funeral home, Rockville, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5838

CERTIFICATE OF DEATH

05825

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 212 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: South Carolina
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Orangeburg
d. STREET ADDRESS: 416 Ellis Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

77X-3

3. NAME OF DECEASED (Type or print): First: Edward; Middle:; Last: MINTZ

4. DATE OF DEATH: Month: May; Day: 18; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-9-47

9. AGE (In years last birthday): 14 yrs. — IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - - -

11. BIRTHPLACE (County & State, or foreign country): South Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lonnie E. MINTZ

14. MOTHER'S MAIDEN NAME: Lillie Mae BILLY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b) Agranulocytosis — 1 month
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

277K

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Malabsorbtion syndrome with ricketts

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from Oct. 18 1960 to May 18, 1961, that ☒ (we) last saw the deceased alive on May 18 1961, and that death occured at 3:43AM, from the causes and on the date stated above.

22a. SIGNATURE: GB Avery M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5-18-61

22c. PHYSICIAN'S NAME (Type): G. B. AVERY, LT, MC, USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment

23b. DATE THEREOF: 5-23-61

23c. NAME OF CEMETERY OR CREMATORY: Church

23d. LOCATION (City, town or county) (State): Orangeburg So. Carolina

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Bacon Funeral Home, 1722 7th St., NW, WashDC

25a. REC'D BY REGISTRAR DATE JUN 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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(M)

(L)

Montgomery South Carolina

Bethesda (Rural) 210 days Orangeburg

U. S. Naval Hospital 910 Ellis Avenue

		KEMETA		MINTZ		May 18	G1
Male	Negro			3-9-47	14		
- - - - - - -			- - - - - - - -		South Carolina		024
Lonnie E. MINTZ					Billie Mae MINTZ		
Mc		None			Hospital Records		

x May 18 G1 Oct. 18 May 18 G1 x

3-18-G1 x

G. H. AVERY, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

Burial-Shipment 7-23-47 Filed Orangeburg So. Carolina

Mason Funeral Home, 1222 7th St., NW, Wash DC June 6 G1 Cash Home

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5839 **CERTIFICATE OF DEATH** 06978

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 24 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, 24
d. STREET ADDRESS: 8411 Galveston Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: Mitchell
4. DATE OF DEATH: Month / Day / Year: May 26, 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 26, 1961
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 2 / Min. 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: William Landon Mitchell
14. MOTHER'S MAIDEN NAME: Mary Carol Darby
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT: mother — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
776X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occured at.....M, from the causes and on the date stated above.

22a. SIGNATURE: H.H. Diamond M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 5-26-61
22c. PHYSICIAN'S NAME (Type): H. H. DIAMOND
22d. ADDRESS: 911 - Silver Spring ave

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 6-8-61
23c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hospital
23d. LOCATION (City, town or county) (State): Takoma Park, Md
24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M. D. Wash. San. & Hospital — ADDRESS:
25a. REC'D BY REGISTRAR: JUN 9 '61 — DATE:
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

VR A15 (4)
15M 9/60

2075191XVO

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5840 — 05826

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 8 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10510 Greenacres Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Lillian — Middle: Ella — Last: Moon

4. DATE OF DEATH: Month: 5 — Day: 23 — Year: 1961

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 7-27-99
9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baby sitter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Ky.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ernest Due — Germany
14. MOTHER'S MAIDEN NAME: Johanna Schaefer — Germany
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give wer or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Washington Sanitarium & Hospital Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive cerebral Hemorrhage — INTERVAL BETWEEN ONset AND DEATH: 9 hrs.
DUE TO (b): Cerebral vascular disease — 5-10 yrs.
DUE TO (c): Mild vascular hypertension — 10+ yrs.

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) —
2Dc. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
2Dd. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) (County) (State) —

21. **I certify** that (I) (~~this hospital~~) attended the deceased from March, 1958 to May 23, 1961, that (I) (~~we~~) last saw the deceased alive on May 23 1961, and that death occured at 8:55 PM, from the causes and on the date stated above.

22e. SIGNATURE: J. Frederick Barr M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-25-61
22c. PHYSICIAN'S NAME (Type): J. Frederick BARR, MD
22d. ADDRESS: 4500 College Ave, College PARK, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Transit-Burial 5/28/61
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Hudson Cemetery
23d. LOCATION (City, town or county) (State): Hudson Iowa

24. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Avenue, Silver Spring, Maryland
Raymond A Zisha
25a. REC'D BY REGISTRAR — DATE: MAY 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5841 — 5827

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ashton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CORDELIA Middle FRANCES Last MOORE
4. DATE OF DEATH: Month May Day 27 Year 19 61
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 3-1-1887
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. SOCIAL SECURITY NO. (If yes give war or dates of service): none
17. INFORMANT: daughter - Frances Konigmacher — Address: 1021 Briggs Chaney Road, Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-27-61
EXAMINER'S NAME (Type): Frank J. Broschart
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 31, 1961
22c. NAME OF CEMETERY OR CREMATORY: Park Lawn Cemetery
22d. LOCATION (City, town, or country) (State): Rockville Montg Co - Md.
23a. FUNERAL DIRECTOR: J. Arthur Walters
ADDRESS: 254 Carroll St. N.W.
24a. REC'D BY REGISTRAR DATE MAY 31 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krama

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 7/59

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5842

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05828

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 6 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 606 University Blvd, West

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 606 University Blvd, West
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

31

3. NAME OF DECEASED (Type or print): First: Marion; Middle: Teresa; Last: Moran

4. DATE OF DEATH: Month: May; Day: 30; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: April 6, 1905

9. AGE (In years last birthday): 56 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Government Employee

10b. KIND OF BUSINESS OR INDUSTRY: Internal Revenue

11. BIRTHPLACE (State or foreign country): Washington, D.C

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ~~Frank~~ Maurice E. O'Connor

14. MOTHER'S MAIDEN NAME: Katie M. Wheatley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT Address: Mrs. Howard P. Hale, 1833 Avenel Rd. Adelphi, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
(b) Rheumatic heart disease — 30 years
DUE TO
(c)

416X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Sept 24, 1956, to May 30, 1961, that I last saw the deceased alive on May 30, 1961, and that death occurred at 8:40 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Raymond Bradshaw, M.D. — ADDRESS (Street, city or town, state): 345 University Blvd, West — DATE SIGNED: 5/30/61

PHYSICIAN'S NAME (Type): Raymond Bradshaw — Silver Spring, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 6/2/61

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Prince George's Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska — ADDRESS: Warner E. Pumphrey, Inc. 8434 Georgia Avenue Silver Spring, Md.

24a. REC'D BY REGISTRAR DATE: JUN 6 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5843 — 05829

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 13 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1018 Woodside Parkway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carolyn — Middle: May — Last: Nau

4. DATE OF DEATH: Month: 5 — Day: 1 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb 17-1890
9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house-wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: C. Edward Day
14. MOTHER'S MAIDEN NAME: Edith V. Laird Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mabel Ames — Address: 1018 Woodside Pkwy, SS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO (b): Hypertensive Cardiovascular Disease — 10 years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4434

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from July, 1955, to May 1, 1961, that (I) (~~we~~) last saw the deceased alive on April 30 1961, and that death occured at 9:7 A.M. from the causes and on the date stated above.

22a. SIGNATURE: James M. Whitlock M.D. — M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-1-61
22c. PHYSICIAN'S NAME (Type): James M. Whitlock
22d. ADDRESS: 7717 Carroll Ave, Takoma Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 3, 1961
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Prince George County Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zaka — ADDRESS: WARNER E. PUMPHREY INC. 8434 Georgia Ave. Silver Spring, Md.
25a. REC'D BY REGISTRAR: DATE MAY 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5844

CERTIFICATE OF DEATH

65831

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 24 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Norfolk
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norfolk
d. STREET ADDRESS: 201 Maycox Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen — Middle: (None) — Last: Nichols

4. DATE OF DEATH: Month: May — Day: 18, — Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 28, 1913
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Tsoukatos
14. MOTHER'S MAIDEN NAME: Constance Kalodimas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
DUE TO (b) Mixed mesodermal Tumor of Uterus — 8 months
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1744

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from April 24, 1961, to May 18, 1961, that I (we) last saw the deceased alive on May 18, 1961, and that death occurred at 6:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Benjamin A. Borowsky M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5/18/61
22c. PHYSICIAN'S NAME (Type): BENJAMIN A. BOROWSKY, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 5-18-61
23c. NAME OF CEMETERY OR CREMATORY: Forest Lawn Cem.
23d. LOCATION (City, town, or county) (State): Norfolk, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE: MAY 23 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5845 **CERTIFICATE OF DEATH** 05832

Item 23b Film G288 6/12/61 mh

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 39 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8405 Dixon Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

25 1

3. NAME OF DECEASED (Type or print): First: Mark; Middle: Leroy; Last: NOLL

4. DATE OF DEATH: Month: May; Day: 28; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12-25-99

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steamfitter

10b. KIND OF BUSINESS OR INDUSTRY: Private Industry

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Elmer S. NOLL

14. MOTHER'S MAIDEN NAME: Margaret BARTHO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): 7-17-17 to 8-12-19

16. SOCIAL SECURITY NO.: 579-14-5616

17. INFORMANT: (W) Mrs. Flora L. Noll, same as #2 above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic carcinoma of — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO (b) the bronchus
DUE TO (c)

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

1621

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from April 19, 1961 to May 28, 1961, that ☒ (we) last saw the deceased alive on May 28, 1961, and that death occured at 4:10PM, from the causes and on the date stated above.

22a. SIGNATURE: Paul G. Linaweaver, Jr., M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5-29-61

22c. PHYSICIAN'S NAME (Type): Paul G. LINAWEAVER, JR., LT, MC, USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 1, 1961

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska

ADDRESS: Silver Spring, Md.

W. E. Pumphrey Funeral Home, 8434 Georgia Ave.

25a. REC'D BY REGISTRAR DATE: JUN 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

1

5846

05833

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens San.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6311 Kirby Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: S. — Last: Offenheiser
4. DATE OF DEATH: Month: 5 — Day: 25 — Year: 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/31/82
9. AGE (In years lost birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engraver
10b. KIND OF BUSINESS OR INDUSTRY: Private
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles J. Offenheiser
14. MOTHER'S MAIDEN NAME: Katherine Hopper
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Yes Unknown
17. INFORMANT: William F. Offenheiser-son-same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal Failure & Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Heart Disease — 8 years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 1957 to May 25, 1961, that (I) (we) last saw the deceased alive on 5-23 1961, and that death occurred at 12:40 p.m., from the causes and on the date stated above.

22a. SIGNATURE: Philip R. James M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/25/61
22c. PHYSICIAN'S NAME (Type): Philip R. James — Ph. Philip R. James
22d. ADDRESS: Washington Clinic, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
23b. DATE THEREOF: 5/27/61
23c. NAME OF CEMETERY OR CREMATORY: South Church Cemetery
23d. LOCATION (City, town, or county) (State): Bergenfield, New Jersey

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: MAY 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hoque

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5847 — 05834

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4512 Leland St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: Delmer a — Last: Phipps
4. DATE OF DEATH: Month: May — Day: 20 — Year: 1961

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/24/80 (1880)
9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AWF
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: FRANK P. BORE
14. MOTHER'S MAIDEN NAME: Carolina Wilhelm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Lester Phipps (Son) — Address: 4512 Leland St. Bethesda

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): Peripheral venous thrombosis — unknown
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
465X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral infarction, cerebral thrombosis, left middle cerebral artery
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2 May, 1961, to 5/20, 1961, that (I) (we) last saw the deceased alive on 20 May 1961, and that death occured at 11:20 pM, from the causes and on the date stated above.

22a. SIGNATURE: John G. Boll, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): John G. Boll
22d. ADDRESS: 7936 Old Georgetown Rd, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL, (Specify): Burial
23b. DATE THEREOF: 5-24-61
23c. NAME OF CEMETERY OR CREMATORY: Middletown Cemetery
23d. LOCATION (City, town or county) (State): Freeland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: J. Jacob Hartenstein, New Freedom, Pa.
25a. REC'D BY REGISTRAR DATE: MAY 23 '61
25b. REGISTRAR'S SIGNATURE: Clifton E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5846 Item 23b, Film G287 5/15/61 iwk 5/16/61 iwk Items 8 & 9 Film G287 00835

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 3824 Denfeld ~~Street~~ Ave,

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3824 Denfeld ~~Street~~ Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle SLADE Last PLOWMAN
4. DATE OF DEATH: Month May Day 4, Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Apr. 11, ~~1883~~ 1884
9. AGE (In years last birthday): 77 ~~78~~ yrs.
IF UNDER 1 YEAR: Months 0 Days 23
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Siderographer - Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: Samuel James Plowman
14. MOTHER'S MAIDEN NAME: Isabel Perine
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife Address: Same as Item 2.
Adelaide Cobb Plowman

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		Interval between onset and death
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Right Heart failure	3 months
DUE TO (b)	Emphysema - chronic bronchitis	20 yrs.
DUE TO (c)		

502.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from March, 1951, to 5-4, 1961, that (I) (~~we~~) last saw the deceased alive on 5-4 1961, and that death occured at 7 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Alfred S. Norton M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 5, 1961
22c. PHYSICIAN'S NAME (Type): ALFRED S. NORTON
22d. ADDRESS: 4711 Highland Ave., Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 5/9/61
23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cem., via Burr Davis Fun. Home, Mt. Vernon, N.Y.
23d. LOCATION (City, town or county) (State): New York City, N. Y.

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE: MAY 9 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5843 — 65836

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 61 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsburg
d. STREET ADDRESS: 567 Singer Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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75X-3

3. NAME OF DECEASED (Type or print): First: John — Middle: Allen — Last: PRUNTY
4. DATE OF DEATH: Month: May — Day: 25 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-10-39
9. AGE (In years last birthday): 22 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U. S. Marine Corps
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - - -
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Clevetta PRUNTY

I

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): 1956 to DOD
16. SOCIAL SECURITY NO.: 176-32-0535
17. INFORMANT: (M) Mrs. Clevetta Wilborn, Address: 172 Mayflower St. Pitts., Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Nephroblastoma, Right Kidney & metastases
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

18a X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

2

21. I certify that ☒ (this hospital) attended the deceased from March 25 1961 to May 25, 1961 that (☒ (we) last saw the deceased alive on May 25 1961, and that death occured at 1:45AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert T. Brooks Jr. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-25-61
22c. PHYSICIAN'S NAME (Type): Robert T. BROOKS, JR., LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment
23b. DATE THEREOF: 5-26-61
23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial Park
23d. LOCATION (City, town or county) (State): Pittsburg Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co.
ADDRESS: WashDC
W.W.Chambers Funeral Home, 1400 Chapin St., NW,
25a. REC'D BY REGISTRAR DATE: MAY 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5850 — 058 57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1135 Loxsford Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thelma — Middle: Elizabeth — Last: Pyle

4. DATE OF DEATH: Month: May — Day: 11 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 24, 1907
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur M. Anderson
14. MOTHER'S MAIDEN NAME: Uda G. Remmington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: --66---
17. INFORMANT: Wm. H. Pyle — Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.
153.8
DUE TO (b) Carcinoma of colon — 11 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 19 60 to 5/11 19 61 that (I) (we) last saw the deceased alive on 5/9/ 19 61, and that death occured at 8:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: Donald Nelson M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/11/61
22c. PHYSICIAN'S NAME (Type): Donald Nelson
22d. ADDRESS: 10120 Georgia Ave Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/15/61
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: 4739 Balt. Ave. Hyattsville, Md.
25a. REC'D BY REGISTRAR: MAY 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5851 65838

M 050 I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 40 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
d. STREET ADDRESS: Box 1236
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Deborah; Middle: Lynn; Last: Randall
4. DATE OF DEATH: Month: May; Day: 23; Year: 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 15, 1958
9. AGE (In years last birthday): 3 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: David E. Randall, Jr.
14. MOTHER'S MAIDEN NAME: Margaret Thomas
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis Right Medial Lobe and Left Upper Lobe and extensive Pneumonitis. — INTERVAL BETWEEN ONSET AND DEATH: 2-3 Weeks
DUE TO
(b) Cystic Fibrosis of the Pancreas — 3 Years
DUE TO
(c) Diffuse Emphysema; Respiratoryacidosis — 1-2 Yrs;1 mo.

587.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April 13 19 61 to May 23 19 61, that (I) (we) last saw the deceased alive on May 23 19 61 and that death occurred at 12:15 am/pm from the causes and on the date stated above.

22a. SIGNATURE: Hugh E. Evans, M.D. M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-23-61
22c. PHYSICIAN'S NAME (Type): HUGH E. EVANS, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 25-61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town or county) (State): Suitland Md
24. FUNERAL DIRECTOR'S SIGNATURE: Lemmons Bros. ADDRESS: 1661 Good Hope Rd SE Wash 20 DC
25a. REC'D BY REGISTRAR DATE: MAY 24 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

5852

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05839

M

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: HOWARD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELLICOTT CITY
d. STREET ADDRESS: TRIDELPHIA ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

13X-2

073

3. NAME OF DECEASED (Type or print): First EFFIE — Middle LAVERNA — Last REED
4. DATE OF DEATH: Month MAY — Day 21 — Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/24/06
9. AGE (In years lost birthday): 54 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): TENN.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: DAVID COOK
14. MOTHER'S MAIDEN NAME: GERTIE FRAZIER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: HOSPITAL RECORDS, OLNEY, MD. — Address

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS
DUE TO
(b): XXXXXXXXXXXXXXXXXXXX
DUE TO
(c):

3 31X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): RHEUMATIC ENDOCARDITIS (MITRAL STENOSIS)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 3/27/ 1961 to MAY 21, 1961 that (I) (we) last saw the deceased alive on MAY 20 1961, and that death occurred at A M, from the causes and on the date stated above.

22a. SIGNATURE: Charles S. Whitaker M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/22/61
22c. PHYSICIAN'S NAME (Type): CHARLES S. WHITAKER, M. D.
22d. ADDRESS: CLARKSVILLE, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 23, 1961
23c. NAME OF CEMETERY OR CREMATORY: Sharon Baptist
23d. LOCATION (City, town, or county) (State): West Friendship, Md.
24. FUNERAL DIRECTOR'S SIGNATURE: Olin L. Moberworth — ADDRESS: Damascus, Md.
25a. REC'D BY REGISTRAR — DATE: MAY 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5853 Item 2 Film G287 5/22/61 mh 05840

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b: 5yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Alta Vista Nursing Home.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 4219 Roundhill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Virginia Middle: Alice Last: Reedy.
4. DATE OF DEATH: Month: May Day: 10 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 10 1877
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months: 11 Days: 0 IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Nursing Home Records Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Generalized Arteriosclerosis — 20 yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 19 61 to 10 May 19 61 that (I) (we) last saw the deceased alive on 10 May 1961, and that death occurred at 12:30 from the causes and on the date stated above.

22a. SIGNATURE: W. S. Murphy M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10 May 61
22c. PHYSICIAN'S NAME (Type): Wm. S. Murphy
22d. ADDRESS: 615 W. Montg. Ave. Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/13/61
23c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cem.
23d. LOCATION (City, town, or county) (State): Mt. Jackson, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE MAY 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5854 Item 14 Film G287 5/17/61 mh 05841

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3891 - Porter St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ethel Middle: M. Last: Reese

4. DATE OF DEATH Month: May Day: 8 Year: 1961

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 11/19/07

9. AGE (In years last birthday): 53 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Exec. Secretary

10b. KIND OF BUSINESS OR INDUSTRY: Dept. of State

11. BIRTHPLACE (County & State, or foreign country): Middletown Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W Besswer

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO

16. SOCIAL SECURITY NO. (If yes give wer or dates of service):

17. INFORMANT 5054 Address Ramby Lane (Son) Thos. Rees. Toledo Ohio

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO (b): Myocarditis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.1

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ....., 19....., to MAY 8, 1961, that (I) (we) last saw the deceased alive on .....19....., and that death occured at 9:25 P.M., from the causes and on the date stated above.

22a. SIGNATURE De Witt E. De Lawter M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 5/8/61

22c. PHYSICIAN'S NAME (Type) DeWitt E. DeLawter

22d. ADDRESS 8025 ABERDEEN Rd. Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit

23b. DATE THEREOF: 5-9-61

23c. NAME OF CEMETERY OR CREMATORY: Woodside Cemetery

23d. LOCATION (City, town or county) (State): Middletown, Ohio

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY

ADDRESS: Bethesda, Md.

25a. REC'D BY REGISTRAR DATE MAY 11 '61

25b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 24 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5855 Items 8, 9 & 12 Film 6287 5/26/61 jwb 05842

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 1302 Abbot Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1302 Abbot Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walla; Middle:; Last: Rehnberg
4. DATE OF DEATH: Month: May; Day: 10; Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 29, 1889 1899
9. AGE (In years last birthday): 71 yrs. 61
IF UNDER 1 YEAR: Months: 7; Days: 11
IF UNDER 24 HRS.: Hours:; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: --------
11. BIRTHPLACE (County & State, or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? Sweden
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 127-14-1333
17. INFORMANT: Gloria Fleming-Daughter-Same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEPATIC FAILURE — INTERVAL BETWEEN ONSET AND DEATH: One Month
DUE TO (b) RENAL FAILURE — 6 months
DUE TO (c) CARCINOMA OF GALLBLADDER — One year

155.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): GENERALIZED METASTASIS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from MARCH 26, 1961, to MAY 11, 1961, that (I) (we) last saw the deceased alive on MAY 10 1961, and that death occured at 8:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Gordon S Rosenberger M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: MAY 10, 1961
22c. PHYSICIAN'S NAME (Type): Gordon S. Rosenberger
22d. ADDRESS: 310 W. Montg. Ave, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 5/15/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town or county) (State): Suitland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: MAY 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Items 1 to 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

Montgomery

Rockville

1302 Abbot Road

Wells

Female White x

Gouverie

Unknown

Maryland

Rockville

1302 Abbot Road

Rehberg May 10 61

Sept. 29, 1889 72 7 11

Sweden

Unknown

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5856 — 65843

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 16 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): WASHINGTON SANITARIUM & HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LANGLEY PARK
d. STREET ADDRESS: 7914 14th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1656-2

075

3. NAME OF DECEASED (Type or print): First — Middle — Last: REID
4. DATE OF DEATH: Month: MAY — Day: 9 — Year: 1961
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 8, 1961
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 16 — Min. 30
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Stephen Sidney Reid
14. MOTHER'S MAIDEN NAME: MARILYN JANET WHITMORE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give wars or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Stephen Reid — Address: 7914 14th St.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ATELECTASIS — INTERVAL BETWEEN ONSET AND DEATH: 16½ hrs.
DUE TO (b)
DUE TO (c)
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last.

762.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PREMATURITY

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 5-8, 1961, to 5-9, 1961, that (I) (~~we~~) last saw the deceased alive on ..... 19....., and that death occured at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: Mary K. L. Sartwell, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-9-61
22c. PHYSICIAN'S NAME (Type): Mary K.L. Sartwell, M. D.
22d. ADDRESS: 6811 Riggs Rd., Hyattsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 5-9-61
23c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hospital, Takoma Park, Md.
23d. LOCATION (City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M. D.
ADDRESS: Washington Sanitarium and Hosp.
25a. REC'D BY REGISTRAR: MAY 10 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2075237 X13

x

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5857 **CERTIFICATE OF DEATH** 65844

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 11600 Orebaugh Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Harry Middle Irving Last Reininga
4. DATE OF DEATH: Month May Day 9 Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-19-18
9. AGE (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner
10b. KIND OF BUSINESS OR INDUSTRY: Laundry Quick
11. BIRTHPLACE (County & State, or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Harry Reininga
14. MOTHER'S MAIDEN NAME: Jane James

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): Army W.W2
16. SOCIAL SECURITY NO.: 351-65-7180
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 months
162.1
DUE TO (b):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 19 61 to May 8, 19 61, that (I) (we) last saw the deceased alive on May 8 19 61, and that death occured 3:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: George William Ware M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/9/61
22c. PHYSICIAN'S NAME (Type): George William Ware
22d. ADDRESS: 183 S. Eye St NW.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 5/12/61
23c. NAME OF CEMETERY OR CREMATORY: Gate Of Heaven
23d. LOCATION (City, town or county) (State): Montgomery Co. Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc. Raymond A. Ziska — ADDRESS: 8434 Georgia Ave, Silver Spring, Md.
25a. REC'D BY REGISTRAR: DATE MAY 15 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5858 **CERTIFICATE OF DEATH** 05845

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 39 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berkley Springs
d. STREET ADDRESS: - - - - - -
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harold — Middle: Alston — Last: RICE
4. DATE OF DEATH: Month: May — Day: 25 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-29-94
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Educational Adviser
10b. KIND OF BUSINESS OR INDUSTRY: ICA
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Frank RICE
14. MOTHER'S MAIDEN NAME: Bertha FISHER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.:
17. INFORMANT: (W) Mrs. Eleanor Rice, same as #2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aneurysm (ascending aorta) with rupture into
DUE TO (b) left lung Etiology undetermined (One day post operative)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from April 16, 1961, to May 25, 1961, that ☒ (we) last saw the deceased alive on May 25 1961, and that death occured at 10A M, from the causes and on the date stated above.

22a. SIGNATURE: James E. McClenathan M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 5-25-61
22c. PHYSICIAN'S NAME (Type): James E. MC CLENATHAN, CDR, MSC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-29-61
23c. NAME OF CEMETERY OR CREMATORY: Greenway Cemetery
23d. LOCATION (City, town or county) (State): Berkley Springs W. Va.
24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey - F.D. — ADDRESS: R. A. Pumphrey Funeral Home, Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAY 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

James B. MC GINNEHAN, CDR,MSC,USN U. S. Naval Hospital,Bethesda, Md.

Burial 5-29-61 Greenway Cemetery Berkley Springs W. Va.

R. A. Pumphrey Funeral Home, Bethesda, Md.

1

FOR STATE HEALTH DEPT.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5853 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05846

Item 14 Film G287 5/24/61 jwk

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 901 Pershing Dr.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: ~~Md~~ D.C.
b. COUNTY: ~~Monty~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 612 N St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

4 7 X 3

3. NAME OF DECEASED (Type or print): First: Frank — Middle: Richardson — Last:

4. DATE OF DEATH: Month: May — Day: 9 — Year: 1961

5. SEX: male

6. COLOR OR RACE: col

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-22-10

9. AGE (In years last birthday): 50 yrs.

IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Timmi Richardson

14. MOTHER'S MAIDEN NAME: Mandy unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: M.C. Police — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Friedlander's Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN

DUE TO (b):

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

✓ 491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

Address (Street, city, town, or county):

DATE SIGNED: 5-9-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/13/61

22c. NAME OF CEMETERY OR CREMATORY: County Home

22d. LOCATION (City, town, or country) (State): Rockville, Md.

23. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR: DATE MAY 15 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M.S. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5860 05847

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 6 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAYTONSVILLE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANCIS — Middle GUY — Last RIORDAN

4. DATE OF DEATH: Month MAY — Day 12, — Year 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1-21-1893

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT

10b. KIND OF BUSINESS OR INDUSTRY: GENERAL

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: EDWARD RIORDAN

14. MOTHER'S MAIDEN NAME: ANNA BRIGHTWELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW1

16. SOCIAL SECURITY NO.: 217 32 1739 → Unknown

17. INFORMANT — Address: HOSPITAL RECORDS, OLNEY, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intra-Cranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days.
331X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 5-6 1961 to 5-12 1961, that (I) (~~we~~) last saw the deceased alive on 5-11 1961, and that death occurred at 2⁴⁰ P.M. from the causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-12-61

22c. PHYSICIAN'S NAME (Type): JACK SCHUMACHER, M. D.

22d. ADDRESS: GAITHERSBURG, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-15-61

23c. NAME OF CEMETERY OR CREMATORY: St. Peter's

23d. LOCATION (City, town, or county) (State): Libertytown, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber

ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR DATE MAY 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5861

Reg. Dist. No. 05848

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: Five years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 170 Glenmont - Colesville Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 170 Glenmont - Colesville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15

3. NAME OF DECEASED (Type or print): First: Charles; Middle: Edgar; Last: Robey

4. DATE OF DEATH: Month: May; Day: 16; Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 7, 1872
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months: 5; Days: 9
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Business
10b. KIND OF BUSINESS OR INDUSTRY: Wholesale Druggist
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John H. Robey — Maryland
14. MOTHER'S MAIDEN NAME: Alexenia Roby — Maryland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 577-07-1328
17. INFORMANT: Miss Lucille C. Robey — Address: 170 Glenmont - Colesville Rd. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Urinary Tract infection — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO
450.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Amputation Left leg — 2 months
DUE TO
(c) Arteriosclerosis — 20 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: 4.00 a.m. Month: death; Day: 5/16/61; Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January, 1961, to 5/16/61, 19____, that I last saw the deceased alive on 5/13/61, 19____, and that death occurred at 4.00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Bernard H. Ostrow M.D. ADDRESS (Street, city or town, state): 8107 Eastern Avenue Silver Spring, Md. DATE SIGNED: May 16, 1961

PHYSICIAN'S NAME (Type): Bernard H. Ostrow

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/18/61
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Montgomery County Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Yeiser — ADDRESS: Warner E. Pumphrey, Inc 8434 Georgia Ave. Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE: MAY 22 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5862

CERTIFICATE OF DEATH

05849

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 132 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Triangle
d. STREET ADDRESS: 25 Courtney Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carl — Middle: Albert — Last: ROHLOFF
4. DATE OF DEATH: Month: May — Day: 3 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-10-34
9. AGE (In years last birthday): 26 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Officer
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Marine Corps
11. BIRTHPLACE (County & State, or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Henry B. ROHLOFF
14. MOTHER'S MAIDEN NAME: Anna Mae PURCELL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): 1956 to 1961
16. SOCIAL SECURITY NO.: 377-30-0979
17. INFORMANT: (W) Mrs. Marilyn A. Rohloff, same as # 2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Leukemia, acute, monocytic — INTERVAL BETWEEN ONSET AND DEATH: 5 months
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

204.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X (this hospital) attended the deceased from Dec. 22 1960 to May 3 1961, that (I) (we) last saw the deceased alive on May 3 1961 and that death occured at 12:35PM, from the causes and on the date stated above.

22a. SIGNATURE: Joseph E. Stitcher M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-3-61
22c. PHYSICIAN'S NAME (Type): Joseph E. STITCHER, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-5-61
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. Inc.
ADDRESS: W.W.Chambers Co., 3072 M St.,NW, Washington,DC
25a. REC'D BY REGISTRAR DATE: MAY 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 9/60

Montgomery Virginia

Bethesda (Naval) 132 days Triangle

U. S. Naval Hospital 25 Courtney Drive x

Cert Albert HOBLOFF May 3 61

x

Male Caucasian 7-10-34 26

Officer U.S.Marine Corps Michigan USA

Henry B. HOBLOFF Anna Mae FUCHELL

Yes 1956 to 1961 377-30-0973 (W) Mrs. Marilyn A. Hobloff, same as # 2 above

Leukemia, acute, monocytic 5 months

x

x May 3 61 Dec. 22 60 May 3 61 x

12:35PM

x 5-3-61

Joseph B. STRUNNK, JR, MC, USN U. S. Naval Hospital, Bethesda, Md.

Burial 5-5-61 Arlington National Arlington Virginia

W.W.Chambers Co., 3012 M St.,NW, Washington,DC

1

5863

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05854

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Barnesville
c. LENGTH OF STAY IN 1b: 7 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Giles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pareasburg
d. STREET ADDRESS: 15X-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertha — Middle: Payne — Last: Ross
4. DATE OF DEATH: Month: May — Day: 23 — Year: 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 22-1911
9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S
13. FATHER'S NAME: James Hewitt
14. MOTHER'S MAIDEN NAME: Martha Sarver
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Albert Ross, Barnesville, Md — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion — 20 minutes
DUE TO (b) Coronary Artery Disease (Arteriosclerosis) — 8 months
DUE TO (c) Hypertensive-Cardiovascular Disease — 2 years

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 May, 1959, to 23 May, 1961, that I last saw the deceased alive on 23 May, 1961, and that death occurred at 11:03 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Gordon M. Smith, M.D. — ADDRESS (Street, city or town, state): Barnesville, Md. — DATE SIGNED: 23 May 61

PHYSICIAN'S NAME (Type): Gordon M. Smith

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/26/61
22c. NAME OF CEMETERY OR CREMATORY: Monocacy
22d. LOCATION (City, town, or county) (State): Beallsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Constance C. Hilton — ADDRESS: Barnesville, Md
24a. REC'D BY REGISTRAR: DATE MAY 31 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Trace

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5864 — 05851

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 9809 Montauk Avenue
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances — Middle: — Last: ROZNOSKI

4. DATE OF DEATH: Month: May — Day: 25 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-7-86
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - - - -
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Martin ROZNOSKI
14. MOTHER'S MAIDEN NAME: Katherine (unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (D) Mrs. Laverne Koon, same as #2 above — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — 3 weeks
DUE TO (b) Malignant Teratoma — 3 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that ☒ (this hospital) attended the deceased from May 15, 1961 to May 25, 1961, that (☒) (we) last saw the deceased alive on May 25 1961, and that death occured at 6:00AM, from the causes and on the date stated above.

22a. SIGNATURE: James M. Young M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-25-61
22c. PHYSICIAN'S NAME (Type): James M. YOUNG, LT, MC, USN
22d. ADDRESS: U. S. NAVAL HOSPITAL, BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment
23b. DATE THEREOF: 5-26-61
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town or county) (State): Toledo Ohio

24a. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: R. A. Pumphrey Funeral Home, Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAY 29 '61
25b. REGISTRAR'S SIGNATURE: Charles S. Ferris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Montgomery Maryland Montgomery

Bethesda (Rural) 10 days Bethesda

U. S. Naval Hospital 9609 Montrose Avenue x

Frances NORWOOD May 29 61

Female Caucasian x 11-7-96 74

Housewife - - - - - Ohio U.S.A.

Maria NORWOOD Katherine (unknown)

No None (H) Mrs. Laverne Kohn, same as #2 above

x May 25 61 May 15 61 May 25 61 x

James M. YOUNG, Lt, MC, USN U. S. NAVAL HOSPITAL, BETHESDA, MD.

Burial-Engagement 5-26-61 Calvary Cemetery Toledo Ohio

R. A. Humphrey Funeral Home, Bethesda, Md.

1

5865

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

45852

M

050

1

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Virginia b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 3854 North Second Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

23X-3

3. NAME OF DECEASED (Type or print): First: Paul Middle: Emmerson Last: Runion

4. DATE OF DEATH Month: May Day: 16 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: December 1, 1954
9. AGE (In years last birthday): 6 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Owen Runion
14. MOTHER'S MAIDEN NAME: Avis Funkhouser

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: immediate

754.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Congenital Heart Disease, Tetralogy of Fallot — 6 years

DUE TO (c) Corrective cardiac surgery — 6 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 14, 1961 to May 16, 1961, that (I) (we) last saw the deceased alive on May 16, 1961, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

22a. SIGNATURE Allan Goldblatt M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED 5/17/61
22c. PHYSICIAN'S NAME (Type): ALLAN GOLDBLATT, M.D.
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 5-17-61
23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Cemetery
23d. LOCATION (City, town, or county) (State): Faulks Run, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE MAY 23 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5866

CERTIFICATE OF DEATH

65853

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 17 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7111 Carroll Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 7111 Carroll Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First SEMU — Middle – — Last SATO

4. DATE OF DEATH: Month 5 — Day 11 — Year 1961

5. SEX: Female
6. COLOR OR RACE: Oriental
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Sept. 19, 1880
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Japan
12. CITIZEN OF WHAT COUNTRY? Japan ✓

13. FATHER'S NAME: ? Yamaguchi
14. MOTHER'S MAIDEN NAME: Not Available

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Florence Nishimoto — Address: (7409 Holly Ave. Tak Pk. Md)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Uremia	24 h.
DUE TO (b)	Congestive failure c̄ hypertension	5 yrs.
DUE TO (c)	Cerebro vascular accident	5 yr.

331 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 1953 to May 1961, that (I) (we) last saw the deceased alive on 5-11 1961 and that death occurred 6:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Ernest A. Sarao M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/11/61
22c. PHYSICIAN'S NAME (Type): ERNEST A. SARAO,
22d. ADDRESS: 7006 New Hampshire Ave. Tak Pk. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: May 13, 1961
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
23d. LOCATION (City, town, or county) (State): Prince Georges County, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Mathes — ADDRESS: 254 Carroll Ave N.W. D.C.
25a. REC'D BY REGISTRAR: DATE MAY 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5867

CERTIFICATE OF DEATH

05854

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norbeck (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Bradford Rest Home

090

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg.,
d. STREET ADDRESS: R. F. D. # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CARRIE — Middle — Last SATTERFIELD

4. DATE OF DEATH: Month May — Day 21, — Year 19 61

5. SEX: female
6. COLOR OR RACE: colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 23, 1889
9. AGE (In years lost birthday): 71 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S. A.

I

13. FATHER'S NAME: Lawerence Braxton
14. MOTHER'S MAIDEN NAME: Barry Luckett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Hazel Kennedy — Address: 2001 Maryland Ave., N. E Wash. D. C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcenoma generalized — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
170X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Breast cancer
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension C.R.D.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug 30 1960 to May 21 1961, that (I) (we) last saw the deceased alive on May 20 1961, and that death occurred at 1:12 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Nehlig Stewell, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-24-61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/25/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington National.,
23d. LOCATION (City, town, or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR — DATE: MAY 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur J. Fisher

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G287 5/15/61 jwk

5868

CERTIFICATE OF DEATH

Reg. Dist. No. 05855

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase
c. LENGTH OF STAY IN 1b 3½ years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4604 DeRussey Parkway

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase SS
d. STREET ADDRESS 4604 DeRussey Parkway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELLA Middle M. Last SCHNEIDER
4. DATE OF DEATH: Month May Day 6 Year 19 61
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH May 9, 1885
9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR: Months 11 Days 27 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME George Brandt
14. MOTHER'S MAIDEN NAME unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Daughter Address ~~4868 Ch.Ch.Blvd.~~ Mrs. Erling B. Saxhaug Chevy Chase, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia, left, acute — INTERVAL BETWEEN ONSET AND DEATH: 7 days.

DUE TO (b) Cerebral Arteriosclerosis — 5 yrs +

DUE TO (c) Arteriosclerosis, generalised.

334X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 19 46 to May 6 19 61 that I last saw the deceased alive on May 5 19 61 and that death occurred at 9:30 a.m. from the causes and on the date stated above.

ACTUAL SIGNATURE Stewart Clapp M.D. ADDRESS (Street, city or town, state) 4740 Chevy Chase Dr. DATE SIGNED 5-6-61

PHYSICIAN'S NAME (Type) Stewart Clapp Chevy Chase, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 5-9-61
22c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery
22d. LOCATION (City, town, or county) (State) Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.
24a. REC'D BY REGISTRAR DATE MAY 9 '61
24b. REGISTRAR'S SIGNATURE Christian L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5869

CERTIFICATE OF DEATH

Reg. Dist. No. 05856

M

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b 15 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Le Deau Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mass.
b. COUNTY Hampshire
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northampton
d. STREET ADDRESS ---- 58 X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

09

3. NAME OF DECEASED (Type or print) First Mary Middle A. T. Last Schoeneck

4. DATE OF DEATH Month May Day 12 Year 19 61

I

5. SEX Female
6. COLOR OR RACE Caucasian
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Oct 31, 1876
9. AGE (In years lost birthday) 84 yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Mother
10b. KIND OF BUSINESS OR INDUSTRY Smith College
11. BIRTHPLACE (State or foreign country) New York City, N. Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Richard Speight
14. MOTHER'S MAIDEN NAME Mary Marvin Todd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 019-26-0836
INFORMANT Mrs Edith F. Thomas 2238 Washington Ave. Address Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hyperpyrexia (Influenza?) — INTERVAL BETWEEN ONSET AND DEATH: 3 days
334X
DUE TO (b) Arteriosclerosis, Generalized with Cerebral Degenration
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 23 61, 19____, to May 12 61, 19___, that I last saw the deceased alive on May 12, 19 61, and that death occurred at 10:30 pm, from the causes and on the date stated above.

ACTUAL SIGNATURE Robert T. Thibadeau M.D. ADDRESS (Street, city or town, state) 10609 Concord Street DATE SIGNED May 12, 61

PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D. Kensington, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Transit-Burial 5/16/61
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY Fountain Hill Cemetery
22d. LOCATION (City, town, or county) (State) Deep River, Middlesex Co., Conn.

23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Zska
ADDRESS Warner E. Pumphrey, Inc., Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE MAY 17 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Kime

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5870

CERTIFICATE OF DEATH

05857

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 41 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2113 Plyers Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louis; Middle: Frank; Last: SHABEK

4. DATE OF DEATH: Month: May; Day: 17; Year: 1961

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-29-88
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Navy
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James SHABEK
14. MOTHER'S MAIDEN NAME: Mary SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW #1
16. SOCIAL SECURITY NO.: 577-48-4778A
17. INFORMANT: (W) Mrs. Mary L. Shabek, same as #2 above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis
DUE TO (b): Carcinoma of pancreas
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
157X

INTERVAL BETWEEN ONSET AND DEATH: unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from April 6, 1961 to May 17, 1961, that ☒ (we) last saw the deceased alive on May 17, 1961, and that death occured at 11:05 PM, from the causes and on the date stated above.

22a. SIGNATURE: C W Bramlett M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-18-61
22c. PHYSICIAN'S NAME (Type): C. W. BRAMLETT, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment
23b. DATE THEREOF: 5/19/61
23c. NAME OF CEMETERY OR CREMATORY: Magnolia Cemetery
23d. LOCATION (City, town or county) (State): Defuniak Springs Florida

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Biska
ADDRESS: W.E.Pumphrey Funeral Home, Silver Spring, Md.
25a. REC'D BY REGISTRAR DATE MAY 23 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Montgomery Maryland Montgomery

Bethesda (Rural) Hi dwye Silver Spring

U. S. Naval Hospital 2113 Figure Mill Road X

Louis Frank GRABER May 17 61

Male Consolain 10-29-88 72

Marinet U. S. Navy Maryland USA

James SHEAR Mary SMITH

Yes WW 61 377-88-1774 (W) Mrs. Mary L. Graber, same as #2 above

X

X

X

May 17 61 April 6 61 May 17 61 X

11:03PM

X 5-18-61

C. W. BRAMLETT, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

Burial-Shipment Magnolia Cemetery Deltonia Springs Florida

W.J.Humphrey Funeral Home, Silver Spring, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5871 — 65858

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 7 hrs. 40 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington, 42
d. STREET ADDRESS: 3602 - Knox St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward — Middle: H — Last: Sherman

4. DATE OF DEATH: Month: May — Day: 19 — Year: 1961

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/14/01
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Woodward & Lothrop
11. BIRTHPLACE (County & State, or foreign country): England
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George E. Sherman
14. MOTHER'S MAIDEN NAME: Susan Tenney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Dorothy B. Sherman — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis, left — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.
332X
DUE TO (b): Cerebral arteriosclerosis — 5 yrs+
DUE TO (c): Essential Hypertension, severe — 25 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral thrombosis, old.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ....., 1950 to May 19, 1961, that (I) (✓) last saw the deceased alive on May 19, 1961, and that death occured at 6:50 p.m., from the causes and on the date stated above.

22a. SIGNATURE: Stewart Clapp, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5.19.61
22c. PHYSICIAN'S NAME (Type): Stewart Clapp
22d. ADDRESS: 4740 Chevy Chase Dr. Chevy Chase Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit
23b. DATE THEREOF: 5/23/61
23c. NAME OF CEMETERY OR CREMATORY: Ft. Hill Cemetery
23d. LOCATION (City, town or county) (State): Auburn, New York

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR: MAY 23 '61 — DATE
25b. REGISTRAR'S SIGNATURE: Arthur S. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5872

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05859

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sunshine
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R-1 Brookville

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sunshine
d. STREET ADDRESS: R-1 Brookville
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert; Middle: Murphy; Last: Shearer

4. DATE OF DEATH: Month: May; Day: 21; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-19-1900

9. AGE (In years last birthday): 60 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired

10b. KIND OF BUSINESS OR INDUSTRY: farmer

11. BIRTHPLACE (State or foreign country): Pa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Shearer

14. MOTHER'S MAIDEN NAME: Mary Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO

(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 185-30-3884

17. INFORMANT: Emilie J. Campbell — Address: Ithan 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage + laceration — INTERVAL BETWEEN ONSET AND DEATH: sudden

976X

DUE TO (b): Shot gun wound of skull

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Self inflicted shot gun wound

20c. TIME OF INJURY: Hour p.m. 2; Month, Day, Year: 5-21 1961

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home

20f. (City or town): Sunshine (County): Montg (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

Address (Street, city, town, or county):

DATE SIGNED: 5-21-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 5-24-61

22c. NAME OF CEMETERY OR CREMATORY: East Waterford

22d. LOCATION (City, town, or country) (State): East Waterford, Penn.

23. FUNERAL DIRECTOR: Francis H. Barber — ADDRESS: Laytonsville, Md.

24a. REC'D BY REGISTRAR: DATE MAY 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO DEPARTMENTAL MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5873

CERTIFICATE OF DEATH

65860

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District Of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 6439 2nd Place, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M

050

4 7 X - 3

3. NAME OF DECEASED (Type or print): First: Mollie — Middle: None — Last: Sindler

4. DATE OF DEATH: Month: May — Day: 25, — Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: August 18, 1959
9. AGE (In years last birthday): 1 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Washington D.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Abraham Sindler
14. MOTHER'S MAIDEN NAME: Marilyn Friedman

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Niemann-Pick Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 mos.
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

289.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

0

21. I certify that (I) (this hospital) attended the deceased from May 20, 1961, to May 25, 1961, that (I) (we) last saw the deceased alive on May 25, 1961, and that death occurred at 2:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Alexander Deutsch M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-25-61
22c. PHYSICIAN'S NAME (Type): Alexander Deutsch M.D.
22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 25, 1961
23c. NAME OF CEMETERY OR CREMATORY: Beth David Cemetery
23d. LOCATION (City, town, or county) (State): Elmont, Long Island N.Y.

24. FUNERAL DIRECTOR'S SIGNATURE: Goldberg Funeral Home — ADDRESS: 4217 9th Street N.W.
25a. REC'D BY REGISTRAR DATE: MAY 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

1

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5874 Items 23c & d, Film G287 5/15/61 lwk 05861

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

050

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1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 21 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Loudoun
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aldie
d. STREET ADDRESS: P.O. Box 171 83X-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nina — Middle: Marie — Last: Smallwood
4. DATE OF DEATH: Month: May — Day: 8, — Year: 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: November 25, 1956
9. AGE (In years last birthday): 4 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Robert Smallwood
14. MOTHER'S MAIDEN NAME: Ruby M. Poston
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gram negative septicemia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b) Acute lymphatic leukemia — 6 months
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

204.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from April 17, 1961, to May 8, 1961 that ☒ (we) last saw the deceased alive on May 8, 1961, and that death occurred at 1:35 PM from the causes and on the date stated above.

22a. SIGNATURE: Richard E. Rieselbach M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5/8/61
22c. PHYSICIAN'S NAME (Type): Richard E. Rieselbach, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial.
23b. DATE THEREOF: 5/10/61
23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Cemetery, Upperville
23d. LOCATION (City, town, or county) (State): Round Hill, Virginia.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Joseph F. Birch's 3034 M Street, N.W. Wash. D.C.
25a. REC'D BY REGISTRAR — DATE: MAY 10 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A1S (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5875 — 05862

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 50 Bethesda
d. STREET ADDRESS: 4712 South Chelsea Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Harvey — Middle: L. — Last: Smith
4. DATE OF DEATH: Month: May — Day: 20 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/28/89.
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired.
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (County & State, or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Robert Smith
14. MOTHER'S MAIDEN NAME: Martha Cutcagar
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): World War I
16. SOCIAL SECURITY NO.:
17. INFORMANT: Frances T. Smith, Address: Same as above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary atelectasis — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Aspiration — Sudden
DUE TO (c): Esophageal achalasia — unknown

539.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Advanced Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ....., 19..., to May 20, 1961, that (I) (we) last saw the deceased alive on May 20, 1961, and that death occured at 2:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: George A. Gray M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): George A. Gray M.D.
22d. ADDRESS: 4740 Cheverly Chase Dr. Cheverly Chase Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/24/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cem.
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: MAY 23 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5876 — 05863

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 45 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md. (D.C)
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5117 Scarsdale Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Julia — Middle: A — Last: Smith

4. DATE OF DEATH: Month: May — Day: 10 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 8/9/01

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurses Aide

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY?: U.S.A 1921

13. FATHER'S NAME: Ludwig Pitsch

14. MOTHER'S MAIDEN NAME: Julia Ann Krompóst

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give war or dates of service): Yes Unknown

17. INFORMANT: Son Robert Smith — Address: 3900 Tenlow Rd. Washington, D.C

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Increased Intracranial Pressure — INTERVAL BETWEEN ONSET AND DEATH: 4 Days
170 X
DUE TO (b) Cerebral Metastatic Disease — 6 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Carcinoma of the Breast — 2 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19 —

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) (County) (State) —

21. I certify that (I) (this hospital) attended the deceased from 2-1, 1961, to 5-10, 1961, that (I) (we) last saw the deceased alive on 5-4 1961, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Francis C. Mayle M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/10/61

22c. PHYSICIAN'S NAME (Type): Francis Mayle

22d. ADDRESS: 8218 Wisconsin Ave Bethesda 14 Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Bur, Transit

23b. DATE THEREOF: 5/12/61

23c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery

23d. LOCATION (City, town or county) (State): Cambria County, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 15 61

25b. REGISTRAR'S SIGNATURE: Arthur L. Hirsch

Item 18 Film 287 5-23-61

1 FOR STATE HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5877 — 05864

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): WASHINGTON SANITARIUM AND HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 10107 Greenock Road
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

31 / 1

3. NAME OF DECEASED (Type or print): First: Phyllis — Middle: Wauna — Last: Snow

4. DATE OF DEATH: Month: May — Day: 5 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 8/16/13

9. AGE (In years last birthday): 47 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oregon

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Shepherd

14. MOTHER'S MAIDEN NAME: Jean Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 537-24-7372

17. INFORMANT: Hospital record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pending Cerebral necrosis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
332 X
DUE TO (b) Cerebral anoxia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Undetermined

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): Frank J. Broschart, M.D.

Address (Street, city, town, or county):

DATE SIGNED: May 5, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): XXXXX

22b. DATE THEREOF: May 9, 1961

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

22d. LOCATION (City, town, or country) (State): Prince George's Co., Md.

23. FUNERAL DIRECTOR: Raymond A. Zieka — ADDRESS: Warner E. Pumphrey, Inc., 8434 Georgia Ave., S.S. Md.

24a. REC'D BY REGISTRAR DATE MAY 12 '61

24b. REGISTRAR'S SIGNATURE: Carlyn S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5878

CERTIFICATE OF DEATH

65865

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day 5 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. 14
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring Rd. 1
d. STREET ADDRESS: Holly Grove Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marion — Middle: B. — Last: Steward

4. DATE OF DEATH: Month: May — Day: 21 — Year: 1961

5. SEX: female

6. COLOR OR RACE: colored

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3/27/97

9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Wm. Steward

14. MOTHER'S MAIDEN NAME: Isabella Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ruth A. Slaughter — Address: Silver Sp. Md. R.F.D. #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Hypertension — not known
DUE TO (c):

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/20, 1961, to 5/21, 1961, that (I) (we) last saw the deceased alive on 5/20 1961, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Abraham W. Davis M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — **22b.** DATE SIGNED: 5/21/61

22c. PHYSICIAN'S NAME (Type): ABRAHAM W DAVISH

22d. ADDRESS: 917 Pershing Dr. Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/26/61

23c. NAME OF CEMETERY OR CREMATORY: Hopkins Church.

23d. LOCATION (City, town, or county) (State): Highland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md.

25a. REC'D BY REGISTRAR DATE: MAY 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5879 — 05866

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park.
c. LENGTH OF STAY IN 1b: 6 hrs-
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Oakhaven Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md-
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 901 Davis
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First (Stilmar) Middle Clara B. Last Stilmar
4. DATE OF DEATH: Month May Day 28 Year 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 15, 1878
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife - Teacher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Bennett
14. MOTHER'S MAIDEN NAME: Emmaline Houx
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Edward Christianson (daughter) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs
422.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 1956 to May 28 1961, that (I) (we) last saw the deceased alive on May 25 1961, and that death occurred at 12:00 p.m., from the causes and on the date stated above.

22a. SIGNATURE: James M. Everitt MD M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-29-61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 7717 Carroll Ave, Takoma Park 12 Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: May 29-1961
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town, or county) (State): Prince Geo. Md.
24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Wallace — ADDRESS: 254 Carroll St. N.E.
25a. REC'D BY REGISTRAR: DATE MAY 31 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5880 05867

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural
c. LENGTH OF STAY IN 1b 4yr 5mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown
d. STREET ADDRESS The Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First ~~Ethe~~ Middle Mary F. Last Starck
4. DATE OF DEATH Month May Day 1 Year 1961

5. SEX female
6. COLOR OR RACE Cauc
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH Feb 27 1877
9. AGE (In years last birthday) 84 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodward & Lothrop
10b. KIND OF BUSINESS OR INDUSTRY Department Store
11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Martin Mapes
14. MOTHER'S MAIDEN NAME Hattie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 579-37-3792
17. INFORMANT Ethel H. Starck Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable myocardial infarction
420.1
DUE TO
(b) Arteriosclerotic cardiovascular disease (many yrs)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) None of significance
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/23 1957 to 5/1 1961, that (I) (we) last saw the deceased alive on 5/1 1961, and that death occurred at 8:15 AM, from the causes and on the date stated above.

22a. SIGNATURE John P. Martin, Jr. M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) JOHN P. MARTIN MD
22d. ADDRESS MEDICAL CENTER, SILVER SPRING

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF May 4. 1961
23c. NAME OF CEMETERY OR CREMATORY National Memorial Park
23d. LOCATION (City, town, or county) (State) Falls Church. Virginia

24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walters ADDRESS 254 Carroll St NW DC
25a. REC'D BY REGISTRAR DATE MAY 3 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kuna

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1 FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5881 — 65868

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: 12 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 3282 Cummings Lane

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: Cummings Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Guillermo — Middle: A. — Last: Suro
4. DATE OF DEATH: Month: May — Day: 12 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-7-1907
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chief - Publications
10b. KIND OF BUSINESS OR INDUSTRY: Pan Am. Sanitary Bureau
11. BIRTHPLACE (State or foreign country): Porto Rico
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: G. Suro-Parado
14. MOTHER'S MAIDEN NAME: Carmen Suro Nunez
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 217-42-8463
17. INFORMANT: Rudad - Suro — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): History of previous coronary attack

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 5-12-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: MAY 15, 1961
22c. NAME OF CEMETERY OR CREMATORY: GATE of HEAVEN
22d. LOCATION (City, town, or country) (State): SILVER SPRING, MD.
23. FUNERAL DIRECTOR: Joseph Sauers Sons — ADDRESS: WASH., D.C.
24a. REC'D BY REGISTRAR DATE: MAY 15 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5882 · **CERTIFICATE OF DEATH** 05869

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 1912 So Wilson
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: ~~b~~ IOWA
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MASON City
d. STREET ADDRESS: 53X-3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: VICTOR Middle: WARREN Last: SWARTZ

4. DATE OF DEATH: Month: 5 Day: 1 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/22/1887
9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): MASON City, IOWA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

I

13. FATHER'S NAME: ANTONE CASPER SWARTZ
14. MOTHER'S MAIDEN NAME: MARGARUITE COOK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 482-32-7798
17. INFORMANT: CHARLOTTE SWARTZ — Address: 1912 S. Wilson MASON City, IOWA

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pulmonary emboli, multiple — INTERVAL BETWEEN ONSET AND DEATH: 1-3 day
465X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Multiple superficial Gastric Ulcers
19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12 April, 1961, to May 1, 1961, that (I) (~~we~~) last saw the deceased alive on May 1 1961, and that death occured at 12:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Jack Crowell M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 1, 1961
22c. PHYSICIAN'S NAME (Type): JACK CROWELL
22d. ADDRESS: 2025 EYE St. N.W Washington, D.C

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/4/61
23c. NAME OF CEMETERY OR CREMATORY: Park Lawn Cem.
23d. LOCATION (City, town or county) (State): Rockville Md

24 FUNERAL DIRECTOR'S SIGNATURE: Cherry Chase Funeral Home — ADDRESS: 5103 Wis Ave Wash DC
25a. REC'D BY REGISTRAR DATE: MAY 4 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5883

CERTIFICATE OF DEATH

65870

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
STATE: Virginia — b. COUNTY: Campbell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lynchburg
d. STREET ADDRESS: 1403 Club Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

83 X-2

3. NAME OF DECEASED (Type or print): First: Cheryl — Middle: Lynn — Last: Tarkington

4. DATE OF DEATH: Month: May — Day: 22 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 25, 1952

9. AGE (In years last birthday): 8 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward H. Tarkington

14. MOTHER'S MAIDEN NAME: Jean Richcreek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give year or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intracranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO (b): Acute lymphatic leukemia — 15 months
DUE TO (c):

2043

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from May 16, 19 61 to May 22, 19 61, that ☒ (we) last saw the deceased alive on May 22 19 61, and that death occured at 1:20PM, from the causes and on the date stated above.

22a. SIGNATURE: Richard E. Rieselbach M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/22/61

22c. PHYSICIAN'S NAME (Type): Richard E. Rieselbach, M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 25, 1961

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery

23d. LOCATION (City, town or county) (State): Lynchburg, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: W. D. Dingwell Inc. — ADDRESS: Lynchburg, Virginia

25a. REC'D BY REGISTRAR DATE: MAY 25 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(1)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5884 — 05871

Item 9 Film 0287 5/17/61 mb

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 75 MINUTES
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ~~Maryland~~
b. COUNTY: DISTRICT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 15 — 47 X 3
d. STREET ADDRESS: 2920 McKINLEY ST., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: EVELYN — Middle: --- — Last: TECKEMEYER

4. DATE OF DEATH: Month: MAY — Day: 11, — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: MAY 12, 1906

9. AGE (In years last birthday): 54 ~~55~~ yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): TENNESSEE

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ? MATTINGLY

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: HOSPITAL RECORDS, OLNEY, MARYLAND — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION
~~DUE TO~~
(b) CORONARY SCLEROSIS
~~DUE TO~~
(c) ACUTE PULMONARY EDEMA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2:50 PM 5/11 1961 to 3:34 PM 5/11 1961, that (I) (we) last saw the deceased alive on 5/11 1961, and that death occurred at 3:34 PM, from the causes and on the date stated above.

22a. SIGNATURE: A. D. Bonifant M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): A. D. BONIFANT, M. D.

22d. ADDRESS: SANDY SPRING, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 5/13/61
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
23d. LOCATION (City, town, or county) (State): Bladensburg Rd. Md

24. FUNERAL DIRECTOR'S SIGNATURE: Cherry Cherry Funeral Home, Wash. D.C.
ADDRESS: 5103 Hay Ave N.E.

25a. REC'D BY REGISTRAR DATE: MAY 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5885 **CERTIFICATE OF DEATH** 65872

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 8 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Oakhaven Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 6066629-81st St, Cabin John, Md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

090

3. NAME OF DECEASED (Type or print): First: Thornton; Middle: B.; Last: Titus
4. DATE OF DEATH: Month: May; Day: 22; Year: 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 13, 1875
9. AGE (In years lost birthday): 85 yrs. — IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Edward Titus
14. MOTHER'S MAIDEN NAME: Mary Ann McKimmy
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 212-24-4693
17. INFORMANT: Elizabeth Witt — Address: 6629-81st St. Cabin John Md

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.
DUE TO
332x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIOSCLEROSIS GENERAL — 5 yr.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

0

21. I **certify** that (I) (this hospital) attended the deceased from JULY, 1959, to MAY 22, 1961, that (I) (we) last saw the deceased alive on MAY 21 1961, and that death occurred at 11 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Leo M. Curtis M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Leo M. Curtis
22d. ADDRESS: 8218 Wisconsin Ave., Bethesda, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/25/61
23c. NAME OF CEMETERY OR CREMATORY: Union
23d. LOCATION (City, town, or county) (State): Leesburg, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home — ADDRESS: 1331 E. Montg. Ave. Rockville, Md.
25a. REC'D BY REGISTRAR: DATE MAY 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G287 5/22/61 mh

CERTIFICATE OF DEATH

5886

Reg. Dist. No. 05873

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: FAIRLAND NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY (Prince George)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 8110 New Hampshire Ave. (FAIRLAND ROAD)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

1856-2

096

3. NAME OF DECEASED (Type or print): First FRANCES Middle — Last ULRICH
4. DATE OF DEATH: Month MAY Day 16 Year 1961

5. SEX: FEMALE
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: NOV. 1897
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SALESWOMAN
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): RUSSIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SOLOMON KRASNER
14. MOTHER'S MAIDEN NAME: HANNAH EISENBERG

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-36-2724
INFORMANT: STANLEY K. ULRICH
Address: 8110 NEW HAMPSHIRE AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CA of the sigmoid — INTERVAL BETWEEN ONSET AND DEATH: 6 MOS
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

153.3

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11, 1960, to 5/15, 1961, that I last saw the deceased alive on 5/15, 1961, and that death accurred at 8 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: B. A. Robin M.D.
PHYSICIAN'S NAME (Type): BENNETT A. ROBIN, M.D.
ADDRESS (Street, city or town, state): 317 UNIV. BLVD. EAST, SILVER SPRING, MD.
DATE SIGNED: JU. 8-8700

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL (Specify)~~: BURIAL
22b. DATE THEREOF: 5/18/61
22c. NAME OF CEMETERY OR CREMATORY: BETH DAVID CEMETERY
22d. LOCATION (City, town, or county) (State): ELMONT-L.I., N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: BERNARD DANZANSKY & SONS
ADDRESS: 3501-14 ST NW
24a. REC'D BY REGISTRAR: DATE MAY 18 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5887 Item 6 Film G286 5/8/61 jjk

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05874

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 1 mo
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kensington Gardens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 3847 Rodman St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John, Middle Lawrence, Last Vail
4. DATE OF DEATH: Month May, Day 1, Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-11-78
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cabinet maker - Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Vail
14. MOTHER'S MAIDEN NAME: Narcissa Lawrence
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 441-01-1084
17. INFORMANT: Nursing Home Record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO (b) Chronic Cardio-renal disease — month
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: May 1-1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 5/3/61
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or country) (State): Suitland, Maryland

23. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE MAY 3 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5888 — 05875

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
d. STREET ADDRESS: 11967 Andrew Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marin — Middle: Pierre — Last: VINCENT
4. DATE OF DEATH: Month: May — Day: 21 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7-20-92
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical
10b. KIND OF BUSINESS OR INDUSTRY: Hotel
11. BIRTHPLACE (County & State, or foreign country): France
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Desiree VINCENT
14. MOTHER'S MAIDEN NAME: Zenaide BONTOUS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: (S) Rene N. Vincent, 2702 10th St., NE, WashDC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis, generalized — INTERVAL BETWEEN ONSET AND DEATH: years
450.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from May 4, 1961, to May 21, 1961 that ☐ (we) last saw the deceased alive on May 21, 1961, and that death occured at 5:27 PM, from the causes and on the date stated above.

22a. SIGNATURE: Robert G. Muth, M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-22-61
22c. PHYSICIAN'S NAME (Type): Robert G. MUTH, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-24-61
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town or county) (State): Washington D?C.

24 FUNERAL DIRECTOR'S SIGNATURE: W. L. N. — ADDRESS: Nalley's Funeral Home, Mt. Ranier, Md.
25a. REC'D BY REGISTRAR — DATE: MAY 25 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

Montgomery Maryland Montgomery

Bethesda (Hurst) 17 days Wheaton

U. S. Naval Hospital 11307 Andrew Street

Merle Pierre VINCENT May 21 61

Male Caucasian 7-20-92 58

Clerical Hotel France USA

Denise VINCENT Female DONTCUS

No (S) Rene M. Vincent, 2702 Roth St., Me,Washic

Arterosclerosis, generalized years

X

X May 21 61 May 4 61 May 21 61 X

5:27PM

X 5-22-61

Robert G. MURM, LT, MC, USN U. S. Naval Hospital, Bethesda, Md.

Burial 5-24-61 Mt. Olivet Cemetery Washington D.C.

Bailey's Funeral Home, 20. Rankin, Md.

1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5889 — 05876

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 23 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 9118 Redwood Ave

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 9118 Redwood Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elliott — Middle: Lambertt — Last: Wallace
4. DATE OF DEATH: Month: May — Day: 27 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-8-1878
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gov. employee
10b. KIND OF BUSINESS OR INDUSTRY: retired
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Geo. M. Wallace
14. MOTHER'S MAIDEN NAME: Elig. Roberts
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Julia Wallace (wife) — Address: Stm 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐
ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 5-27-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/31/61
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or country) (State): Rockville, Maryland
23. FUNERAL DIRECTOR: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR: DATE JUN 2 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5890 — 65877

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M — 1 — 2 — 1

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 35 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Ann Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — 0210-2
d. STREET ADDRESS: 407 3rd Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hannah — Middle: Catherine — Last: WERT
4. DATE OF DEATH: Month: May — Day: 19 — Year: 19 61
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5-6-80
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - - - -
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Christ RONK
14. MOTHER'S MAIDEN NAME: Mary E. DULL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (S) Charles A. Wert, Jr., same as #2 above — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Arrythmia — 48 hours
DUE TO (b) Arteriosclerotic Heart Disease — 10 years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Staphylococcal pneumonia (2 wks)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (X) (this hospital) attended the deceased from April 14, 1961 to May 19, 1961, that (X) (we) last saw the deceased alive on May 19 1961, and that death occured at 12:35AM, from the causes and on the date stated above.

22a. SIGNATURE: James M. Young M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-19-61
22c. PHYSICIAN'S NAME (Type): James M. YOUNG, LT, MC, USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Shipment
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Maple Grove Cemetery
23d. LOCATION (City, town or county) (State): Elizabethville Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: R. J. Murphy
ADDRESS: Arlington, Va.
Murphy Funeral Home, 3524 Columbia Pike,

25a. REC'D BY REGISTRAR DATE: MAY 23 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

8

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5891 **CERTIFICATE OF DEATH** U5878

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manassas
d. STREET ADDRESS: 191 Old Centreville Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robin; Middle: Denise; Last: WEST
4. DATE OF DEATH: Month: May; Day: 30; Year: 1961
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5-29-61
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months: Days: 1 IF UNDER 24 HRS.: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - -
10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Fred Leon WEST, JR.
14. MOTHER'S MAIDEN NAME: Phyllis Carol ROBBINS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (F) Fred L. West, Jr., Address: same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
761.5
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 27 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prolapsed umbilical cord with asphyxia
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from May 29, 1961 to May 30, 1961, that ☒ (we) last saw the deceased alive on May 30, 1961, and that death occured at 9:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: G B Avery M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-31-61
22c. PHYSICIAN'S NAME (Type): G. B. AVERY, LT, MC, USN
22d. ADDRESS: U S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 6-1-61
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: R. A. Pumphrey
ADDRESS: R. A. Pumphrey Funeral Home, Bethesda, Md.
25a. REC'D BY REGISTRAR DATE JUN 1 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 M C 051 I 2

205122 3 X V 3

Montgomery Virginia

Bethesda (Rural) 1 day Manassas

U. S. Naval Hospital 191 Old Centreville Road X

Robin Denise 4E37 May 30 61

Female Caucasian 5-29-61 1

- - - - - - - - - - - - - - Maryland Gen.

Fred Leon West, Jr.

No Name (2) Fred L. West, Jr., same as (2) above

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5892 — 05879

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: Dead on Arrival
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton
d. STREET ADDRESS: Box 112 — 16X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M 099

3. NAME OF DECEASED (Type or print): First: Frank — Middle: Levy — Last: White

4. DATE OF DEATH: Month: May — Day: 15, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: November 5, 1899

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance Agent

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lee White

14. MOTHER'S MAIDEN NAME: Nettie Payne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unavailable

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Lymphocytic leukemia — INTERVAL BETWEEN ONSET AND DEATH
204.0
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 15, 1961, to May 15, 1961 that (I) (we) last saw the deceased alive on May 15, 1961 and that death occurred at 2:05 P.M., from the causes and on the date stated above.

22a. SIGNATURE: R. Rieselbach M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/15/61

22c. PHYSICIAN'S NAME (Type): R. Rieselbach M.D.

22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: May 17-61 — 23c. NAME OF CEMETERY OR CREMATORY: Christ Church — 23d. LOCATION (City, town, or county) (State): Clinton Md

24. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros — ADDRESS: 1661 Good Hope Rd SE Wash DC

25a. REC'D BY REGISTRAR: DATE MAY 17 '61

25b. REGISTRAR'S SIGNATURE: William S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

5893

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05880

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 7815 GREENWOOD AVE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
d. STREET ADDRESS: GREENWOOD AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First EDNA Middle FLOSSIE Last WILLARD
4. DATE OF DEATH: Month MAY Day 2 Year 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: JULY 27, 1888
9. AGE (In years lost birthday): 72 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): MORGANTOWN, W. VA.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: ZAQUELLEN
14. MOTHER'S MAIDEN NAME: MARY E. LEMON
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: GEORGIA M. WILLARD, Address 7815 GREENWOOD AVE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary Embolism susp.	1 hr.
420.0 DUE TO (b)	Arteriosclerotic Heart Disease	20 yr. est.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 22 1960 to May 2, 1961 that (I) ~~(we)~~ last saw the deceased alive on May 2 1961 and that death occurred at 9 AM, from the causes and on the date stated above.

22a. SIGNATURE: Ralph F. Patten M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/2/61
22c. PHYSICIAN'S NAME (Type): RALPH F. PATTEN M.D.
22d. ADDRESS: 8641 Colesville Road Silver Spring Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 5, 1961
23c. NAME OF CEMETERY OR CREMATORY: FLETCHER M. E. CEMETERY
23d. LOCATION (City, town, or county) (State): MORGANTOWN W. VA.

24. FUNERAL DIRECTOR'S SIGNATURE: Arthur Stokes
ADDRESS: 254 CARROLL ST NW WASH DC
25a. REC'D BY REGISTRAR DATE: MAY 3 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5894 — 05881

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any [illegible] is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 7/59

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 SILVER SPRING
d. STREET ADDRESS: NORWOOD ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GARY Middle ROBERT Last WILLET

4. DATE OF DEATH: Month MAY Day 4 Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/12/60
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 8 Days 22 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WASHINGTON, D. C.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ROBERT WILLET
14. MOTHER'S MAIDEN NAME: RUTH REID

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: RUTH REID Address: ITEM 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

475X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(a) IMMEDIATE CAUSE: ASPHYXIA — INTERVAL BETWEEN ONSET AND DEATH: FOUND
DUE TO
(b) UPPER RESPIRATORY INFECTION — COLLAPSED
DUE TO
(c) — IN BED.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 5/4/61

22a. BURIAL, CREMATION, REMOVAL (Specify): XXXXXX
22b. DATE THEREOF: May 6, 1961
22c. NAME OF CEMETERY OR CREMATORY: Parklawn
22d. LOCATION (City, town, or country) (State): Montgomery Maryland

23. FUNERAL DIRECTOR: Warner E. Pumphrey, Inc.
ADDRESS: 8434 Georgia Ave, S.S. MD.
24a. REC'D BY REGISTRAR DATE: MAY 8 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Raymond A. Zicke

1

5895

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05882

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 10.0.A
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wash. San. & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1212 Noyes Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

075

3. NAME OF DECEASED (Type or print): First: Gertrude — Middle: Josephine — Last: Williams

4. DATE OF DEATH: Month: 5 — Day: 3 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 8-26-88

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HSWF

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Dixon

14. MOTHER'S MAIDEN NAME: Margaret Garison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give were or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ralph Williams — Address: 10118 Pierce Dr Silver Spring, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

420-0

DUE TO (b): Arteriosclerotic Heart Disease c̄ Hypertension — over 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Previous Myocardial Infarction 1955 + 1958

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1955, 19..., to May 3, 1961, that (I) (was) last saw the deceased alive on May 1, 1961, and that death occured at 12 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Warren D. Brill, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Warren D. Brill, M.D

22d. ADDRESS: 2601 - 16th St. N.W. Wash. 9, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 6, 1961

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Mausoleum

23d. LOCATION (City, town or county) (State): Prince Georges Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc. — ADDRESS: 8434 Georgia Ave, S.S.

Raymond A. Zioka

25a. REC'D BY REGISTRAR DATE MAY 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5896 — 65883

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma
c. LENGTH OF STAY IN 1b: 8 1/2 hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Dist. of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1321 - Harvard St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Palmer — Last: Wright
4. DATE OF DEATH: Month: May — Day: 17 — Year: 1961
5. SEX: male
6. COLOR OR RACE: colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/19/15
9. AGE (In years last birthday): 47 yrs. — UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.
11. BIRTHPLACE (County & State, or foreign country): North Carolina U.S.A.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Julius Wright
14. MOTHER'S MAIDEN NAME: Abbie Palmer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): World War II
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. Elizabeth McNeal — Address: (same) 515 Ter

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 Hours
DUE TO (b): Cerebral Hemorrhage — 12 Hours
DUE TO (c): Multiple Myeloma — 14 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

203A

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Uremia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from November, 1960, to May 17, 1961, that (I) (~~was~~) last saw the deceased alive on May 17, 1961, and that death occured at 9:40 pM, from the causes and on the date stated above.

22a. SIGNATURE: Jack Crowell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 17, 1961
22c. PHYSICIAN'S NAME (Type): JACK CROWELL
22d. ADDRESS: 2025 Eye St. N.W. Wash., D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 22, 1961
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Fort Meyer Va

24. FUNERAL DIRECTOR'S SIGNATURE: Frazier Funeral Home 389 R.I. Ave N.W.
ADDRESS:
25a. REC'D BY REGISTRAR: DATE MAY 19 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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